

TRANSFORMING SUBJECTIVITIES: GLOBAL MENTAL HEALTH, BIOPOLITICS, &
DEPRESSION IN CHILE

BY

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ABSTRACT

As the leading cause of disability around the world (WHO 2012), depression has become a major public health concern. The global mental health movement has organized to increase access to mental health care within primary care and to protect the human rights of those who experience mental illnesses. Within this movement, the World Health Organization (WHO) MIND Project which operated in the early 2000s aimed to increase services and legal protections for people with mental illness, through collaboration with national governments and with the assertion that through such collaboration, global psychiatric knowledge would trickle down to the general population. Foucault (1978) has argued that in contemporary society, governance takes place through biopolitics as the “making live” of populations through construction of health problems as simultaneously political and economic ones. Rose (2007) posited that the outcome of living in such a society is the creation of individual-level biological citizenship, where people increasingly see themselves in biological ways. Biological citizenship is theorized as an active process of describing the self in biologically-colored languages while also making demands upon the state for the provision of health care.

This dissertation project examined the potential transfer of psychiatric knowledge from the global organizational level to the level of individuals in Chile, a country claimed as a success of the global mental health movement. This project utilized qualitative, ethnographic methods over a six-month period in Santiago, Chile, to explore the biopolitical management of depression, including discourse analysis, observations, and interviews. Observations took place in the psychiatry departments of two public hospitals. Interviews were conducted with people undergoing treatment for depression at either hospital, care providers working in mental health, and a set of people outside of the medical realm who may or may not have had any experience

with depression. Discourse analysis of texts from global and national levels revealed that the management of mental health, and depression specifically, occurred in ways congruent with biopolitical governance (Foucault 1978, Rabinow & Rose 2006). Observations and interviews showed that depression was seen in contradictory ways, both social and biological. While patients generally felt any of a myriad of interpersonal problems caused their depression, depression was explained as being seen as an illness similar to physical ailments, requiring biomedical intervention. Outsiders and providers more often relied on biological explanations for the mental illness, but all of the interview participants felt depression was on the rise.

Many felt the increase in depression throughout the population was due to society becoming more fast-paced, competitive, and individualistic, with superficial communication and relationships between people. Such feelings of disconnect from the larger population being interpreted as depression represent the medicalization of anomie (Durkheim 1997), in line with biopolitical governance through the inspiration of self-regulation (with regards to pharmaceutical treatments) for the good of the whole. A vast majority of those interviewed were women, who often described their responsibilities as overwhelming them, leading to depression; one woman explained that continuing to hold responsibility over the household in addition to the pressures of the workplace (also called the stalled revolution; Hochschild and Machung 2012) was too much to bear. Through medicalizing women's experiences, such feelings of being overwhelmed are constructed and handled as issues of individual biology rather than problems within the social structure. None of the patients or the outsiders made explicit statements that the state should be responsible for the care of depression, even when asked about health care. The findings from this research indicate the need to widen biological citizenship to include implied biological definitions and passive demands on the state, as a new gradational biological citizenship.

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CHAPTER 1: INTRODUCTION

A slender 47-year-old woman sat in a blue plastic chair along the wall in the crowded office of a psychiatric in-patient ward in Santiago one chilly, rainy Thursday morning. She clasped her hands tightly together in her lap, looking down at them as she explained the suicide attempt that brought her to the hospital the night before. “I don’t want to kill myself,” she said to the eight psychiatrists and advanced medical students sitting around the room, “but neither do I want to be a slave to this family situation.” Sonia¹ told us she was legally responsible for her three neurologically impaired brothers; although she had a successful career as a sociologist, she felt trapped and saddened by feeling she was isolated, on her own, and bearing too much responsibility. After she finished telling her story, the psychiatrists dismissed her from the room and promptly determined the diagnosis: depression.

Sonia is one of over 450 million people globally who experience a mental illness within their lifetime (WHO 2009). In 2008 more than 121 million people were affected by depression (WHO 2009), and by 2012 that number had increased to over 350 million worldwide (WHO 2012). This dissertation project explores the construction and circulation of global psychiatric knowledge as governance through biopolitics, including how such knowledge may play a role in individual experiences of depression in Chile. Ultimately, this dissertation is concerned with addressing the nature of the governance mechanisms offered through the global mental health movement, as well as whether individuals come to see themselves through their mental health

¹ Names of all participants have been changed to pseudonyms to protect confidentiality.

experiences as biological beings as the global mental health movement and theory of governance would suggest.

Depression is currently defined by the World Health Organization's (WHO) International Classification of Diseases (ICD-10) as the lowering of mood, energy, interest, and activity level (WHO 1992). A severe depressive episode, classified as F32, is one occurrence of these symptoms while a recurrent depressive disorder (F33) is multiple occurrences of the severe depressive episode. The ICD-10 recognizes thirteen separate categories of depressive episodes and disorders, not including depressive symptoms as part of other illnesses, such as bipolar disorder or some conduct disorders. Within the Chilean context the prevalence of depression is increasing at alarming rates, from 4.6% in 1992 to over 9% in 2006 (Florenzano Urzua et al. 1995; Vincente et al. 2006; Vincente et al. 2002). The number of people seeking medical care for depression in Chile has increased more than six and a half times – from about 18,000 to over 275,000 people – within the first ten years (2001-2009) of the additional coverage for depression in the national health care plan (Minoletti, Rojas and Sepúlveda 2011). Use of antidepressant medications in Chile has skyrocketed 470% over the twelve-year period from 1992 to 2004 (Jirón, Machado and Ruiz 2008).

Because depression is understood to cause individuals to possibly withdraw from people, activities, and work, it is seen as a debilitating condition and is expected to become the leading cause of disease burden for the world's population by 2020 (WHO 2009). While the ICD-10 does not detail possible causes of depressive episodes or disorders, the primary methods of treatment are anti-depressant medications and psychotherapy. As depression ends in suicide for only 1% of those who experience it, problematizing depression as a debilitating condition causing disruptions in everyday life (rather than an issue of mortality) allows global

organizations, such as the WHO, to formulate programs to address the worldwide increase in depression. Standardized global mental health programs often intervene at the national level of legislation and mandates for clinical practice, abstracted from the people experiencing depression themselves. Such programs at times explicitly expect their initiatives to have “trickle down” effects such that people understand, use, and value psychiatric definitions of disorders and appropriate treatments as soon as they are made more widely available.

As the WHO construction of depression at a global level is used in mental health projects around the world, two important questions emerge: How does the WHO conceptualization of depression affect what people think depression is? What are the major components of depression defined at the global level, and does this knowledge flow down to local levels of intervention as expected by the WHO? This dissertation aims to answer these questions through a qualitative exploration of the meaning and management of depression in Santiago, Chile.

Mental Illness, Mental Health, and Depression

Mental illness up until the 18th century was conceptualized as more of a state of being than as a condition of one’s mind (Berrios 1996). It was not until the 17th century that confinement operations began to cast the mentally ill out of society and keep them away from the non-ill population (Foucault 1965). Foucault argues that the first uses of confinement for mental illness began in 1656 at the Parisian Hôpital Général, which was seen then not as a medical facility but as a jailhouse or prison for those whom the judicial system would place.

The contemporary category we know as depression has its roots in the 19th century western European melancholia (Berrios 1996); by 1860 medical dictionaries included the term “depression,” defined as “reduction in general activity ranging from minor failures in concentration to total paralysis” (p 299). Medical professionals at the time preferred the term

depression because it alluded to the slowing of activity and mental abilities as having a physiological cause.

Studies of depression overwhelmingly show that world-wide, women suffer from the disorder more often than men (Hopcroft and Bradley 2007; Inaba et al. 2005; Van de Velde, Bracke and Levecque 2010). As for race, whites are generally found to have higher rates of depression than minority populations (Riolo et al. 2005; Sclar et al. 2012; Williams and Sternthal 2010). In some US studies that have found African Americans to have higher rates of depression than whites, the disparity almost disappears after controlling for income or SES (Spence, Adkins and Dupre 2011; Walsemann, Gee and Geronimus 2009). The relationship between mental illness and socioeconomic status generally shows higher levels of mental illness for lower classes within a society (Eaton and Muntaner 1999; Hollingshead and Redlich 1958), and the same is true for depression (Inaba et al. 2005; Lorant et al. 2003; Walsh, Levine and Levav 2011).

Sociological examinations of health and illness have relied on several perspectives to explain the existence, handling, and consequences of mental disorders. Medicine conceives of bodies and brains as non-social entities, enticing individuals to see themselves as separate from their bodies (Radley and Billig 1999). However, just as there are real consequences for people who have or are perceived to have certain diseases or disorders, so too are there physical, psychological, and medicalized consequences for people based on their social locations. Social determinants and consequences of mental health have also been studied under this line of thought, particularly with regards to race, class, and gender, as briefly mentioned above with regards to depression. The main finding is that some people in marginalized groups face higher levels of mental illness than their non-marginalized counterparts. Native Americans have been found to have higher rates of alcoholism, depression, and suicide than whites while Latinos have

higher rates of alcohol abuse; African Americans have higher rates of schizophrenia, phobias, and generalized anxiety disorder than do whites (Jackson and Williams 2006; Williams and Collins 1999; Williams and Harris-Reid 1999). In general, class has been found to have an inverse relationship to mental illness; that is, people of lower socioeconomic status have been shown to have higher rates of mental illness (Eaton and Muntaner 1999; Hollingshead and Redlich 1958; Mirowsky and Ross 2003; Williams and Collins 1999). Women have been found to experience higher rates of depression than men, while men experience higher rates of substance abuse and antisocial disorders.

Another argument within the sociology of health and illness is that grouping sets of physical or behavioral traits together and collectively pulling them under a medical gaze represents a covert mechanism of social control of people deemed to be deviant (Conrad 2007; Conrad and Schneider 1992; Scheff 1999; Szasz 1961). Several have argued that psychology specifically medicalizes simple, mundane, every day behaviors which do not require medical treatment (Conrad 2006; Kutchins and Kirk 1997). Attention deficit/hyperactivity disorder (ADHD) has commonly been seen as an example of this medicalization, as children are diagnosed based on behaviors understood to be deviant only within very specific contexts, usually in schools (Conrad 2006; Conrad 2007; Conrad and Schneider 1992; Halas and Hanson 2001; Lakoff 2000; Malacrida 2003; Rafalovich 2004; Singh 2002; Singh 2005). At school, children are expected to sit in their seats and pay attention for hours each day, and when a child does not conform to this expectation they are suspected to have ADHD even though the child may fit in as 'normal' without any behavioral problems in other contexts such as with friends, playing sports, or at home (Halas and Hanson 2001; Rafalovich 2004). The inclusion of homosexuality as a mental illness in the first and second editions of the American Psychiatry

Association's Diagnostic and Statistical Manual (DSM) is another example, as homosexuality was seen as something pathologically wrong because it was a deviant sexuality (Conrad and Schneider 1992). The diagnostic category was removed from the third edition of the DSM in 1973 because of mounting political pressure from the civil rights movement.

Historical examinations of mental illness support the medicalization argument; in the United States Census for the year 1840, there was one category for mental illnesses (Eaton 2001). With the advancement of psychiatry as a science, the foundation of the APA and the development of the DSM, the number of mental illnesses has steadily grown. As of 2001, the APA recognized 357 different mental illnesses.

Year	Agency	Number of Categories of Mental Illness
1840	US Census	1
1880	US Census	7
1917	APA Committee on Statistics	59
1952	DSM-I	128
1968	DSM-II	159
1980	DSM-III	227
1987	DSM-III-Revised	253
1994	DSM-IV	357
2013	DSM-5 ²	277

Table 1: Number of categories of mental illness by year and agency responsible for categorization. Adapted from Eaton 2001.

² Although the number of diagnoses overall decreased from the DSM-IV to the DSM-5, the new release was not without controversy. Major structural changes were made to the DSM in its fifth edition, including the removal of the classic multi-axial system that had defined some previous versions. Global debates were ignited around the release of the fifth edition, for the collapsing of several disorders under the category Autism Spectrum Disorders (APA 2013a), as well as the inclusion of new diagnostic categories such as Hoarding Disorder, Premenstrual Dysphoric Disorder, and Disruptive Mood Dysregulation Disorder (APA 2013b). Many are concerned about the potential for DSM 5 to over-medicalize normal life experiences (Cassels 2013), and others voiced outrage over the connections between the DSM revision task force and the pharmaceutical industry as 67% had direct ties (Cosgrove and Bursztajn 2009, NHS 2013).

Several have argued that health and illness, including mental illnesses, are socially constructed; that is, illness only exists as conditions deemed significant by society (Goldstein 1999), as a matter of social comparison (Radley and Billig 1999). While the majority of diagnostic categories in the ICD-10 as well as the DSM are believed to be universally applicable, a wealth of research supports the existence of additional mental illnesses thought of as ‘culture-bound syndromes,’ applicable only within certain sets of countries or sometimes only in one particular community; that is, culture-bound syndromes are groupings of conditions believed to be significant, but only within the confines of one or a few societies. The most well-known culture-bound syndrome is *shenjing shuairuo* (neurasthenia), which has been a common disorder in Japan and China (Kirmayer 1984). Characterized by somatic symptoms such as headaches, dizziness, and palpitations, neurasthenia may be accompanied by other symptoms such as depressed moods, phobias, and mental fatigue (Mezzich, Ruiperez and Villa 2008).

Illness, disease, and disorder represent specific constructions of knowledge whose definitions and interventions change over time (Rose 2007). Although neurasthenia was present in the American mental health context starting in 1869, it was eliminated from the DSM-III (APA 1980) most likely because practitioners believed the category was too broad, encompassing over 50 symptoms (Lee and Kleinman 2007). Neurasthenia has been reconstituted as depression in the United States, which has proved to be a change with global impacts. From the 1950s until 1980, 80-90% of psychiatric outpatients in China were diagnosed with neurasthenia (Kleinman 1982); because of the global reach of the DSM after 1980 diagnoses of neurasthenia in China have been slowing even though Chinese psychiatrists believe neurasthenia to be a more appropriate diagnosis for their patients (Lee and Kleinman 2007). Clearly, illness conditions deemed significant (or non-significant) in one society, through global circuitry of

knowledge, can impact which illnesses are considered significant in other societies. The ideas of globalization and development will be explored in the following sections both in general and with regards to mental health and illness.

Globalization and Development

Globalization is a buzzword that has been moving through academic and popular discourses for the past 20 years, with varying meanings, connotations, and foci. Generally, the term globalization refers to the circulation or flow of knowledge, money, services, goods, people, and culture around the world (Collier and Ong 2005; Inda and Rosaldo 2008; Pieterse 2004; Sassen 2004; Sassen 2006; Stiglitz 2002; Stiglitz 2006). Although many hope for globalization to improve living standards worldwide, globalization has shown to be based on unequal power relations with disparate impacts on people in specific locales (Pieterse 2004; Stiglitz 2006), resulting in “winners” and “losers.” Globalization has been conceptualized as “time-space compression” (Harvey 1991), meaning that people are connected and processes occur over vast physical distances in very short periods of time due to technological and economic changes which literally make shorter the amount of time necessary for flows of capital, people, and information from one place to another. Similarly, globalization has been thought of as “time-space distancing” (Giddens 1990), emphasizing that social interactions occur not only in local spaces but also, thanks again to technology, across time and space such that the local becomes disembedded from its original geographical space.

While the term “globalization” indicates a general opening up of societies and their becoming more interconnected with other societies around the world for exchange of various forms of capital, the related term “development” more specifically refers to economic improvements within a society or nation (Lawal 2006). “Development” refers to a nationally-

oriented goal of restructuring policies and services to meet the standards of acceptable living within a Western nation (Escobar 1992). It is only through development that some countries and their citizens come to be known as “underdeveloped” or “backwards” and in need of assistance; the popular development view is of societies on a continuum from poverty to proper society, with the final destination being a society that values Western, capitalist goals. Non-developed places are seen as not reaching their full potential. Any country that tries hard enough through the right types of reforms and economic action can escape their “backwardness” to reemerge as a society which values individual rights to accumulate wealth through entering the workforce.

Development and all of its ideals were borne out of political movements in the post-World War II era, originating with then-U.S. President Truman’s vision to better areas of the globe that had not reached their development potential (Escobar 1995; Sachs 1992). The creation of development as a program for global action simultaneously constructed an ideology of development in which certain countries were seen as developed and others as underdeveloped based on their economic status (through GNP) which was understood as the nation’s ability to compete in capitalism. This ideology promotes and values particular forms of intervention (Crush 1995) in the quest to move nations along on the one track of progress that will lead them to modernized and developed status (Esteva 1992). To give aid under development logic is to “help in the overcoming of a deficit” (Gronemeyer 1992:65) which is supposed to allow the receiver to become normal. Those nations which are already seen as developed grant themselves the authority to decide when another (read: underdeveloped) nation is in need of help by virtue of their already having gotten to the modernized status (Goldman 2005; Gronemeyer 1992), which no doubt was through the extraction of resources and exploitation of the very nations they seek to help (Esteva 1992).

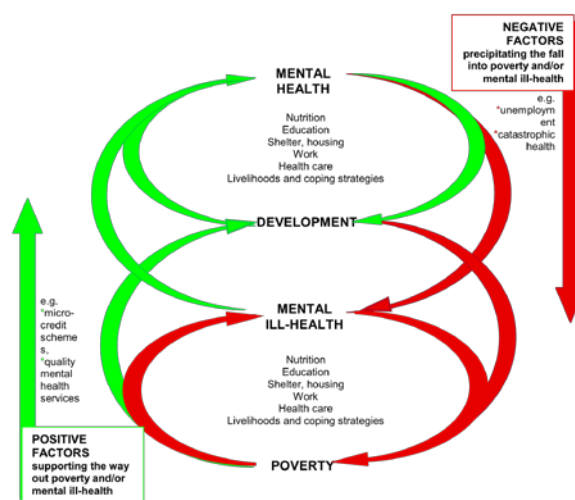
The primary means of judging the development of nations began with examinations of each country's gross national product (GNP), which is the measure of the economic value of a country's goods and services (Esteva 1992). The underlying assumption behind GNP as a measure of development is that greater GNP means greater quality of life. However, GNP as the measuring stick fails to appreciate where that money is going or who it is serving as it only evaluates one aspect of society (that being economics). Putting development in terms of GNP also means that countries are evaluated based on how well they tango with capitalism. Because of the framing of development in terms of GNP, any solutions will inevitably be aimed at the level of the economy. Programs to increase development will aim to raise GNP through increasing economic productivity.

Development and Depression

Economic development is generally perceived among the public to be unquestionably positive, particularly because of the assumption that greater GNP means greater quality of life, and as one may assume, higher levels of happiness (or lower levels of depression, at least). Paradoxically, then, US-based and international studies relating depression to economic status have found that more economic privilege comes more frequently with a higher prevalence of diagnosed depression. The path-breaking 1958 study of social class and mental illness in the United States showed in general that lower classes had higher rates of mental illnesses; however, in the sample population, depressive reactions specifically were more prevalent among people of higher classes (Hollingshead and Redlich 1958). In 1966, depressive disorders represented one third of cases in private mental hospitals while only representing 10% of cases at state and county mental clinics (Kramer 1969); class ability to afford particular types of medical care may be at play in these differences. Although the GNP of the United States increased over \$8.38

billion from the 1940s into the 2000s, life satisfaction remained extremely stable with little, if any, increase over the same sixty-year period (Diener and Seligman 2004). From 1980 to 2009, Chile's GNP increased over \$175 billion (WB 2011) while life satisfaction decreased from 1990 to 2007 (Papastefanou and Rojas 1997; Veenhoven 2011). A recent cross-national study found that the lifetime prevalence of depression was significantly higher in high-income countries like France, Germany, Japan, United States, and New Zealand than it was in low- to middle-income countries such as India, Colombia, Brazil, Lebanon, and Ukraine (Bromet et al. 2011).

Even in light of research showing a correlation between economic status and depression, global organizations have developed and are implementing mental health programs with the dual purpose of improving the economic situations of developing nations while extending access to care for and protections of human rights of those who experience mental illnesses and depression in particular. One example is the WHO's MIND Project (Mental health Improvements in Nations' Development [sic]), aimed at low- and middle-income countries, which operates using the theoretical framework of the negative cycle of poverty and mental illness (see Figure 1). The MIND Project has targeted four specific mental illnesses, depression being one of them.³



³ The other mental illnesses covered by the MIND Project are schizophrenia, alcohol abuse, and drug abuse.

Figure 1: The WHO's negative cycle of poverty and mental illness (WHO 2008).

The project's discourse posits that mental illness and poverty are linked in a negative cycle where those who are mentally ill are more likely to be in poverty because their mental illness makes them unable to work; the other side of the cycle is that those who are in poverty are predisposed to mental illnesses. Using this logic, the WHO has developed the MIND Project to intervene at the level of mental illness through working with nations in creating protective legislation and increasing access to treatments for mentally ill people. The first objective of the project is "concrete changes in people's daily lives" by enabling legislators to change laws and by aiding countries in development of treatment programs. Through this construction of mental illness and poverty, to treat mental illness would mean treating poverty, and while a social explanation of illness is utilized the suggested solutions are biomedical. The explicit logic of the program is that once individuals are able to access treatment for their mental illnesses, they will do so and adhere to treatment schedules such that they will be able to find work and move out of poverty; when achieved on an aggregate level, the WHO posits, the entire nation will rise from poverty on a favorable pathway towards modernization and development. Ultimately, this program could be seen as a form of medicalizing poverty (Moreira 2003) leading to solutions of treating mental illness so the nation will progress to a developed stage.

One may take the WHO's logic to argue that since mental illness may be a cause of poverty, the WHO is implying that nations sustaining a developed status do not have citizens who experience mental ill-health. However, the issue for the WHO is not whether mental illness exists for any level of development; their argument is that the *management* of mental illness is what will allow nations to become upwardly mobile in an economic sense. We must control the

mental illness through calculations of and creation of services for at-risk populations so that the issue no longer stands in the way of the nation state becoming modernized.

Of countries where the MIND Project has been carried out, Chile has been the most successful by the WHO's standards. These successes include drafting and legislative approval of the "Charter of Rights and Duties of Patients," a document to guarantee to people with mental illnesses the same rights as people with physical illnesses, and increased awareness and "sensitization" around mental health issues (WHO 2007). For this reason, Chile was chosen as the site of data collection for this dissertation project, as further explained in Chapters 2 and 3.

Theoretical Framework: Biopolitics and Biological Citizenship

This dissertation works to understand the use of psychiatry through global mental health projects as part of a global discourse constructing and organizing societies based on biological characteristics, features, or afflictions within national populations. The use of power in societies through structuring life around health and well-being has been well elaborated by Foucault, specifically with the concepts of biopower and biopolitics (Foucault 1978; Foucault 2003; Rabinow and Rose 2006). The latter of these will be utilized to theoretically explore global mental health and depression throughout this dissertation.

Biopower is a general term used by Foucault to represent power over life. Up to the 17th century, power was generally used to defend the sovereign by taking life away, exercised during times of threat to the sovereign power. During the 17th century, biopower evolved into a spectrum of possible forms but defined by the two poles at either end (Foucault 1978). The first type of biopower Foucault elaborated was that of anatomo-politics, which is based on seeing individual bodies as machines to be made flexible and docile for efficient use within economic

systems. Anato-mo-politics centers around the disciplining of individual bodies such that their abilities are optimized and extracted through integration in labor processes.

The other pole of biopower, as Foucault conceptualized, is made up of the biopolitics of the population. Within this frame, the focus is not on individual bodies but of the “species body” (Foucault 1978), that is, an entire population. Attention is paid in a biopolitical system not to extracting a disciplined capability from a docile body but to helping the biological processes that enable the living of the population. The general biological characteristics of the population come under sharp scrutiny: birth, death, illness (Foucault 2003). Information is processed about vital statistics such as mortality rates so that regulatory controls can be developed and interventions introduced at the level of the population. Within biopolitics, population health is a scientific and political problem with economic and political effects.

Whereas anato-mo-politics constitute making better what an individual body can do through performance of mechanical tasks, biopolitics envelops making better what the species body is as a biological being⁴. The major difference to Foucault between biopolitics and the earlier use of power by the sovereign is the difference between making live and letting die versus making die and letting live. Biopolitics makes use of anato-mo-politics in its execution, through the individualizing orientation of the biological itself. While statistics are gathered for the population-level, the interventions deployed rest upon biomedical knowledge, placing responsibility on each person to regulate their own bodies in accordance with what makes their bodies as accumulated biological processes operate at optimum functionality, in line with what is best for the common good.

⁴ As Foucault says, biopolitics is “applied not to man-as-body but to the living man, to man-as-living-being” (2003: 242).

Whether anatomo- or biopolitics, Rabinow & Rose (2006) argued that three components were essential to biopower: *truth discourses* about the essential characteristics of living humans, including people considered “experts” who could speak the truth about such characteristics; *intervention strategies* to enact on populations in the name of health; and *modes of subjectification*, or practices exercised by individuals on themselves to enhance their lives.

While Rabinow & Rose posited that these were essential elements of biopower, I would limit these elements to biopolitics because of their focus on the health of the population at large rather than individual bodies. Additionally, the elements they see as essential do not adequately address the extraction of ability or the processes used to make flexible bodies within anatomo-politics. However, the three components elaborated by Rabinow & Rose are very useful in examining how biopolitical certain empirical realities may be; they will be incorporated into the analyses in the coming chapters, particularly Chapter 4⁵.

Foucault’s development of biopolitics demonstrates a framework of how power works within a society focused on health and wellness of its population. As power has historically shifted towards biopolitical management of societies, this begs the question: what effect does this have on the individual? Living within a society focused on the health and well-being of its populace has been theorized to socialize individual citizens to think of themselves and others in terms of their biological existence, creating biological citizenship⁶ (Rose 2007; Rose and Novas

⁵ For Rose & Novas (2005), biopolitics works on two social dimensions: both as individualizing wherein the person acts on him- or her-self, and as collective where people organize around a shared biological status (see Klawiter 2008). The idea of biopolitics inspiring new social organization is also conceptualized by Paul Rabinow (1996) as biosociality. The exploration of biopolitics in this dissertation is limited to the first social dimension.

⁶ A concept of similar definition with the same name was developed by Petryna (2002; 2004) to signify the status of people who placed demands upon the Ukrainian government for rights to medical services and other forms of support because of biological problems experienced as a result of the 1986 Chernobyl disaster. Rose’s work on biological citizenship has is different

2005). Citizenship itself at its core is the legal belongingness of individuals to a collective, historically the state; it also includes the ability for people within the collective to engage politically and the rights afforded to those people. Nation-states have long used biological criteria to define who could be and were citizens, with race being a prime example.

Through processes of globalization, territories and citizenship are being redefined such that citizenship may no longer be based in the nation. Just as notions of citizenship are changing, so too are the ways in which biology is called upon to construct people as political beings. Instead of drawing from proper blood lines to establish who should or should not be a citizen, biological citizenship in the contemporary era calls for people to proactively intervene on their own health to strengthen not only themselves as physical beings but that looking out for one's own health works to strengthen the population at large.

Through knowledge about health disseminated by experts through various "authoritative channels" (Rose 2007:141), people come to understand themselves and others using "biologically colored languages" (Rose 2007:140); that is, they use biological language as a moral guide for action, to describe themselves, their concepts of self, their feelings, and their health conditions. The biological citizen is expected to be active in understanding their biological problems which includes working with professionals to understand whatever conditions they may have as well as taking on techniques of regulating one's self in lines with medical advice to achieve a positive outcome. Biological citizenship is dependent upon scientific understandings of the human species, and represents a new formation of subjectivity.

from Petryna's notion in the former's expansion of the intersection of biology and self-identity, versus Petryna's focus on the importance of the state and belonging to the state as a citizen in people's vying for resources around the biological damage sustained from the Chernobyl incident (Cooter 2008).

This formulation of biological citizenship has been criticized as being too reductionist and structurally-deterministic to be useful in understanding subjectivities (Plows and Boddington 2006); the conceptualization of biological citizenship as subjectivities shaped solely from authoritative, expert sources of scientific information leaves little to no room for agency, or the “talking back” of subjects to their biological status. Rabinow’s (1996) concept of biosociality may be useful in overcoming this criticism. Biosociality characterizes new social formations of collective identity that are being created around biological statuses. Individuals are active in their own health and seeking out others who are like them to form communities of support, understanding, and increased awareness about particular conditions. Through biosociality around breast cancer, for example, public opinion of the disease shifted from stigmatizing to empowering (Klawiter 2000; Klawiter 2008). People who overcome the disease now are seen as triumphant survivors, in contrast to thirty years ago when so many who suffered from breast cancer felt forced to stay silent. Rose argues that this form of activism and responsibility to the collective has become “virtually obligatory” within biopolitical societies for one to be considered a good citizen⁷ (Rose 2007:147).

Research Questions

Considering the theoretical framework of the current project, this dissertation examines depression at global, national, and local levels through the following research questions:

1. How are biopolitical goals reflected in the MIND Project?

⁷ It is possible that Rose may argue that whether one engages in biosocial communities is not left to the freedom of individual agency as he posits biosociality is contingent upon the time and space in which people live. Additionally, Rose (1998; 1999) would say that agency is a false concept: we are free, but only to choose from options granted to us. We are never truly free to create our own selves. Again, though, this would not escape the argument that Rose is overdeterministic.

2. How do the “truth discourses” (Rabinow and Rose 2006) about mental illness, and depression specifically, influence...
 - a. professional practice and subjectivity?
 - b. individual subjectivities of those diagnosed with depression?
 - i. (How) are biopolitical goals reflected in the way people think of depression and their own mental health experiences?
3. What does biological citizenship look like in this specific context?
 - a. Do people (consciously or not) understand themselves and others as biological citizens?
 - b. How does biological citizenship intermingle with a person’s social locations?

To answer these questions, an ethnographic project was carried out for seven months in Santiago, Chile, including six months of observation in the psychiatric wards of two of the largest hospitals in the country. Interviews were conducted with mental health professionals, people diagnosed with depression, and people outside of the medical context who had no experience with depression. Relevant texts and documents about depression were collected and analyzed as well. The methodology for this project will be further explained in Chapter 2.

Significance & Contributions

The globalization of mental health is a controversial field of study; several have theorized that with the help of global organizations, Western ideas about what constitutes mental illness as well as appropriate treatments have become standardized, universalized, and hegemonic (Walker 2008; Watters 2010). Such studies, while significant, utilize a top-down method of determining that as one framework for defining mental illness becomes dominant that this framework replaces all other ways of knowing and understanding what mental illnesses are and how to

experience them. This dissertation project is significant in that while it does explore definitions of depression at the global and national levels, analysis of these levels is not used in a deterministic fashion. Through the use of ethnographic methods to observe and interview people within a setting that has the presence of a global mental health project, this dissertation will contribute to the field a more complete picture of how mental illness is defined without assuming that the global model, once adopted in a country, becomes the only way individuals understand and think of mental illness.

Similarly to the globalization of mental health, Foucault and Rose have been criticized for creating theoretical models of the management (and consequences of management) of individuals which place excessive emphasis on larger social structures and scales without room for human agency. While this dissertation project does rely on the theories of biopolitics and biological citizenship as analytical tools, it does so reflexively by utilizing extended case method as the methodological framework so the data may be used to improve upon the theories. This dissertation makes a theoretical contribution by working towards refined models of biopolitics and biological citizenship.

More recent developments around biopolitics and biological citizenship have taken place through the lens of biomedicalization (Clarke et al. 2003, Clarke et al. 2010). Biomedicalization is a series of processes leading to an intensification of health-oriented discourses, sciences, and technologies, where new technologies are enabled to compartmentalize pieces of the body on smaller and smaller scales to pinpoint the place of and intervene against illness. The body of biomedicalization literature has largely examined the shape of technoscientific advances in health within the United States context; Clarke and colleagues (2010) have called for increased attention to health, medicine, and technoscience around the world as well as how technoscience

and biomedicine operate through public health. The current project contributes to the biomedicalization literature through addressing both of those calls.

Chapters of the Dissertation

Chapter 2 lays out the methodology for the project, including a discussion of the particular methodological framework and tools used to carry out the project, general characteristics of the sample, and ethical complications. Chapter 3 provides a historical background on Chile from which to understand the placement of the MIND Project, including a discussion of the Pinochet dictatorship (1973-1990) and its consequences. Chapter 4 addresses the first research question through a critical biopolitical examination of global level documents related to depression and the MIND Project. Chapter 5 explores the ethnographic data, including observations and interviews, in development of socially-oriented themes around depression to illuminate local understandings of depression in light of the global biopolitical construction of the disorder. Chapter 6 offers a continuation of the development of themes from the ethnographic data, focusing instead on those themes which are more biologically oriented. Chapter 7 concludes the dissertation, including a discussion of the utility of biopolitics and biological citizenship as the guiding theoretical framework for this project, and presents revised theory of biopolitics and biological citizenship from which to consider depression sociologically.

CHAPTER 2: METHODOLOGY

Introduction

This dissertation explores various levels of psychiatric knowledge, questioning the notion that through the biopolitical construction of society individuals within the society will think of themselves as biological citizens. Because of the increasingly globalized nature of the contemporary world and the expansive reach of global health programs, this project starts by dissecting one specific global mental health program (the WHO's MIND project) that had the goal of changing national and personal definitions and handling of mental health, using biopolitics as the analytical tool to examine national level⁸ definitions of depression and finally, what shape biological citizenship takes amongst the population.

Methodological Framework

This project will bring together empirical data collection with an engagement in theory through utilizing extended case method (Burawoy 1998). Extended case method is a technique that requires the researcher to begin with a theory or theoretical framework with which the researcher will comprehend what happens in the field; from empirical ethnographic work, the researcher will make revisions and modifications to the original theory. The benefit of extended case method is that the study is constantly in touch with existing theory, working towards making theory more appropriate for the empirical world as well as allowing the empirical world

⁸ Although processes of globalization may be lessening the importance of the nation as an organizational unit (Rose 2007), the national level is important to investigate in the context of global health since many programs (particularly by the WHO) are contingent upon national government requests, acceptance, or support to enter a country.

to speak to a theoretical level (Burawoy 1991). In this dissertation the theories to be considered are Foucault's original conception of biopolitics and Rose's notion of biological citizenship, as outlined in the previous chapter.

Methods

Ethnography provides an opportunity to understand how particular processes operate within real world settings, including biopower, biopolitics, biosociality, and biological citizenship (Whyte 2009). Using ethnographic methods allow for the creation of "thick description" (Geertz 1973) of subjectivities, enabling deeper understandings of participant meanings as well as the ability to situate them and the field site within the larger context (Taylor and Bogdan 1998).

Specific methods involved in this project are unobtrusive and participant observation, interviews, and collection of discourse about depression. Data from the global level consists of WHO documentation about and from the MIND Project and about depression (including its definition and appropriate treatment). The country chosen as the national example and the site of local ethnographic data collection, as mentioned earlier, is Chile; this country was chosen as the national site location for the project because of its involvement in the WHO's MIND Project as well as the WHO's distinction that the country was an exemplary case of what can be done with the MIND Project. More specific information about the history and system of mental health in Chile will be detailed in the next chapter. National discourses include the Chilean Ministry of Health's (MINSAL) texts about their national health care program, the treatment program for depression, and books about depression written by Chileans that were available through local bookstores in Santiago during the time of ethnographic fieldwork. Observations and interviews serve to inform about local, personal understandings of depression.

Site Visit

A one-month preliminary site visit was conducted from June to July of 2009 to meet key contacts at hospitals in Santiago and determine the feasibility of the project. Through contacting the Chilean Society for Mental Health (*Sociedad Chilena de Salud Mental*), I was directed to three psychiatrists who each worked at different hospitals. Visits were made to each of the three hospitals to meet the psychiatrists, conduct preliminary observations, gain a better understanding of how the mental health system worked in Chile, and assess whether each hospital could serve as a site for the project. The three hospitals visited include *Hospital Barros Luco*, *Hospital del Salvador*, and *Instituto Psiquiátrico Dr. José Horwitz Barak*. All three of the sites are public hospitals; while private hospitals and clinics also exist in Chile, public hospitals were more appropriate sites for the research as 70% of the population uses public insurance (*FONASA*) (Infante 2007; Schaeffer and Valenzuela 2008) and 100% of the population has access to public insurance for the treatment of depression (Araya, Alvarado and Minoletti 2009).

Hospital Barros Luco, located in the San Miguel neighborhood due south of downtown Santiago, serves the southern metropolitan population of about 1.5 million people. While the hospital opened its doors in 1911, it was not until 1970 that the psychiatry department was established at *Hospital Barros Luco* (HBL 2012). The psychiatry department includes short-term stay facilities, a day hospital, outpatient clinic, and psychiatric emergency room. The general hospital building is a new facility, opened in 2002, set back about a quarter of a mile from the main road. According to the head of psychiatry at *Barros Luco*, 90% of people with mental health issues are seen in the hospital, within primary care on the second floor of the main building. This hospital provides service within the first (lowest level of severity) and second (moderate) levels of mental health care within the Chilean health system.

Hospital del Salvador is a general hospital near the center of the city, the second largest hospital in both Santiago and Chile. It opened in 1872 and is currently part of the health system serving the southwestern part of Santiago. A small city in itself, occupying approximately four city blocks, the hospital houses many different departments with colored lines on the floor leading incomers to their desired destinations. The yellow line leads through the hospital's courtyard on elevated, worn tile pathways, through two parking lots back to the furthest building in the northeast corner, the psychiatric clinic. The psychiatric clinic at *Hospital del Salvador* is considered to be at the second of three levels of mental health care within the Chilean health system and contains a clinic, a day hospital, out-patient clinic, and short-term stay facilities. A Chilean woman I spoke with informally outside of the hospital setting referred to *Hospital del Salvador* as the “revolving door” for medical students in Chile, saying that regardless of where the students were from that most would have to do a set of rotations at this hospital.

Instituto Psiquiátrico Dr. José Horwitz Barak is Chile's oldest psychiatric hospital, having opened in 1852. Although the hospital is a resource for some people with moderate mental illnesses, it mostly provides services for those with severe mental illnesses. The hospital primarily serves residents of Santiago based on its location just north of the downtown area, but is available for all Chileans. Its official catchment area includes the neighborhoods north of downtown Santiago as well as a few outlying towns within thirty kilometers of the hospital. There are eight sectors for long term stays for both adolescents and adults, as well as a 24-hour urgent care clinic for mental health emergencies, and a library with a paid librarian. The urgent care clinic was a recent addition, having opened in April 2009.

All three sites were valuable and would have informed the study in important ways as each offered different services for patients, represented various levels of the mental health care

system, were located in diverse areas of the city, and were historically significant. Although key contacts in all three sites guaranteed access for data collection in the larger study, upon arrival in Chile in January 2010 the key contact at *Instituto Psiquiátrico Dr. José Horwitz Barak* believed the climate in the hospital was too politically volatile for a researcher to enter. For this reason, data collection was limited to *Hospital Barros Luco* and *Hospital del Salvador*.

Data Collection

The data was collected from January until August 2010. Observations and interviews took place in the psychiatry wards of two hospitals in Santiago, where the head of psychiatry of each hospital had approved observations. Observations took place for four to five hours each weekday and following each observation extensive fieldnotes were written about the observations⁹ (Emerson, Fretz and Shaw 1995). At *Hospital Barros Luco*, approximately 260 hours of observations were conducted, beginning on February 2, 2010. They took place in the psychiatric day hospital, psychiatric emergency room, and in outpatient interviews that took place between the head psychiatrist and individuals coming for psychiatric services. On two occasions the head of psychiatry approved (and accompanied) observations at a community mental health center (COSAM) in the San Bernardo neighborhood, located approximately 20-30 minutes south of *Hospital Barros Luco* by taxi.

The psychiatric day hospital was located on the back of the hospital grounds, along a dirt road that wound around the psychiatric ward and eventually on to a few surgery buildings. Surrounded by a fence, a cement path led up to the double-doors of the small, single-story building where patients with moderate mental illnesses would come for part of the day to eat

⁹ Although observations included seeing medical interviews with patients, I did not conduct medical interviews with patients as I did not have the proper training to be evaluating a patient's psychological well-being nor the expertise to provide treatment suggestions.

breakfast, hear a lecture about an aspect of mental illness, be part of a group to discuss coping mechanisms or learn how to perform everyday tasks, eat lunch, and leave around mid-afternoon. Patients who attended the day hospital had been referred to do so by a psychiatrist because the state of their mental illness was seen as moderate, although not severe enough to warrant in-patient care.

The psychiatric emergency room at *Hospital Barros Luco* was located on the first floor of the central hospital building. It was a 20 square-foot room with white painted walls, a wooden desk for the psychiatrist on duty to sit, and three chairs. Patients arrived and were seen on an as-needed basis, often accompanied by a family member. Most of the patients who arrived to the psychiatric emergency room were in a state of crisis, such as one eighty-year-old woman in a delusional state, screaming “I am the queen!” and banging on the door to get out of the room as the psychiatrist on duty interviewed the woman’s daughter.

Outpatient interviews with psychiatrists took place in the psychiatry department’s own building which located on a road that wrapped around the central hospital building. Patients would go to these appointments having been referred there or to follow up on past appointments. While there were four offices for patients to see psychiatrists, observations only took place in the outpatient interviews conducted by the head of psychiatry of *Hospital Barros Luco*.

At *Hospital del Salvador*, approximately 190 hours of observation took place starting on April 21, 2010. Observations took place in the psychiatric in-patient ward as well as the weekly clinical seminar series for mental health professionals, and a weekly psychiatry course for medical students. The psychiatric in-patient ward was located across a small parking lot from the main psychiatry building and had been converted from the old maternity ward. Although at one point it had been for both men and women, the in-patient ward at the time of data collection

exclusively served women. Approximately 20 women could be hospitalized at one time, and during the data collection period anywhere from ten to 18 patients were present.

The clinical seminar series took place in a lecture room with stadium style seating, in the main psychiatry building on Wednesday mornings at 10:00 am. Typically lasting two hours, the seminar series presentations were made by invited speakers or mental health professionals who worked at *Hospital del Salvador* about a topic relevant to psychiatry and the patient populations served. The series was open to any mental health professional or medical student working in psychiatry and typically would draw an audience of fifty people, almost filling the room.

In the same lecture room on Wednesday afternoons at 2:00 pm was the psychiatry course for medical students, instructed by the head of psychiatry at *Hospital del Salvador*. Typically, the class would watch a recorded psychiatric interview with a current or recent patient at the hospital, stopping frequently – about every 1-2 minutes – to discuss the responses given by the patients and dissect the patients' psyche. Although class attendance varied from week to week, there were usually twenty students who would come to the course.

Each observation setting was included to provide a more nuanced understanding of how patients and care providers thought of depression. During data collection, special attention was paid to how individuals spoke about their own experiences with depression as well as how they understood what the disorder was and appropriate treatments. In the context of the theoretical framework for the project, this meant listening for how and when the languages used to describe depression synced up with characteristics of biopolitics and biological citizenship.

Interviews were conducted as part of the data collection, to gain insight into how patients, professionals, and outsiders understood what depression was as well as any social ideas that existed around depression. Eighty semi-structured interviews were conducted during this study,

meaning that there was prepared interview guide to follow but I also probed participants for additional responses based on active listening to what they were saying during the course of the interview (Rubin and Rubin 2005; Seidman 2006; Taylor and Bogdan 1998). Interviews were conducted in Spanish, audio-recorded and transcribed. Interview participants¹⁰ included patients diagnosed with depression and mental health professionals (psychiatrists, psychologists, social workers, occupational therapists, medical students, nurses – all who worked in the psychiatry wards). Sampling of these groups occurred by convenience (Babbie 2008) and patient interview participants were chosen based on professional evaluations that the patient would be fit enough for an interview. Fourteen interviews were conducted with mental health professionals and 45 interviews were conducted with people who had been diagnosed with depression. The vast majority of the patient participants were women from the ages of 40-60, and were primarily from lower classes. The mental health professionals on average were slightly younger (30-55), fairly evenly divided between men and women, and were from the middle class.

After several months in the field and many interviews, it became apparent that it would be beneficial to ground what I had been hearing about depression from professionals and patients within the larger social context by gathering interviews with people outside of the medical realm (“outsiders”) who were neither mental health professionals nor people suffering from depression. Original IRB approval was received on December 3, 2009¹¹, but additional IRB clearances were secured later to collect interviews with participants from the general population through convenience and snowball sampling (Babbie 2008; Taylor and Bogdan 1998). Twenty-one interviews were collected in this manner. The average age of the outsiders was 20-35, and they

¹⁰ Appendix A provides a table with a list of all interviewees by pseudonym.

¹¹ Approval was also received from the bioethics committees at both hospitals.

were closer to an even mix of men and women. Most of the outsiders were from the middle class.

Forty-seven texts were collected to explore depression and psychiatric knowledge globally and in Chile¹². Texts were collected partially by convenience and partially by being publically available. Some texts were gifted by mental health professionals from each site. Relevance was determined based on how directly the text discussed depression or the MIND Project. Thirty-five of the texts overall came from Chile, including newspaper articles, books published by the Ministry of Health and popular publishing companies. Twelve of the texts came from the global level (published by the WHO). One text which comes from the United States is included in the national list of texts because the key contact at *Hospital Barros Luco* explained that it was the “bible” of community psychiatry, which guided the structure of mental health services and interactions with patients at that site. Of the 47 texts, 23 were determined to be of high relevance.

Sample Biases and Limitations

There are a few demographic differences within the group of interview participants that bias the sample. First, the average ages of each group are different. It is possible that cohort effects may play into the responses to the interview questions, particularly the questions about historical changes in Chilean social perceptions surrounding depression and the perceived influence of the dictatorship. The majority of the patient participants were alive before the dictatorship and thus were able to more easily see its effects whereas many of the outsiders were born during the dictatorship and would therefore not have a basis of comparison for life before Pinochet took power. Secondly, the class differences between the samples may also play into

¹² A table of the texts appears in the Appendix, including the titles and authors of the texts, which level they represent (global or national), and their relevance for the project.

any differences in responses, in two regards. To begin, many of the people in the outsiders category had attended college whereas most of the people in the patients group had never attended a university; several of those diagnosed with depression had not completed high school. It is possible that people from the middle class had more exposure to academic conceptions of depression through education. Additionally, multiple studies have shown an inverse relationship between socioeconomic status and psychiatric disorders, including depression (Kohn, Dohrenwend and Mirotznik 1998; Ortiz-Hernández, López-Moreno and Borges 2007). While this means that outsiders may have less exposure to depression as personal experience it also points to the importance of including those diagnosed with the disorder who come from lower class backgrounds as interview participants.

There are a few biases within the sample of collected texts as well. First, all of the texts collected from the global level represent what was publicly available (and primarily through the WHO website) during the time of data collection. It is possible that other information existed about the project that was not available. Additionally, the books and newspapers that were collected, while publicly available, may not be completely accessible to the entire population. Books in Chile are moderately expensive; several of the books collected cost between \$20.00 USD to \$30.00 USD each. Although the books were all purchased in public book stores, the prices were prohibitively high for the lower classes. While newspapers generally cost around \$1.00 USD each even this small amount could greatly impact a lower class family¹³, so it is

¹³ During an observation of outpatient interviews at a COSAM facility, the mental health professionals in the room said that a barrier for treatment for one specific man was that the cost of public transportation, at 500 Chilean pesos (CLP; about \$1.00 USD) each way, was too high for him to afford even though the care he would receive would have been free of charge. The head of the psychiatry department at the corresponding hospital, who was present at the time, took a 1000 CLP note out of his wallet and gave it to the man during the interview, with the stipulation the man use the money to get to the hospital within the next few days for an

possible that the newspapers were not as widely consumed as they could be. Unfortunately during the time of data collection, no public libraries were checked to see whether books or other materials on depression were available for loan so the accessibility of some of the texts in that regard is questionable.

Data Analysis

As per usual qualitative research methods, data analysis for this project began simultaneously with data collection (Taylor and Bogdan 1998). This technique allowed for analysis to be in dialogue with data collection, as additional question or topics of interest may arise during the analysis process. Several memos were written about the research findings and process during data collection. Memos are an important part of qualitative research as they provide the researcher with space to think about what is occurring in field sites (Corbin and Strauss 2008; Emerson, Fretz and Shaw 1995). Analysis also included a multi-stage process of coding fieldnotes, memos, and interview transcripts. This process began with open coding (Corbin and Strauss 2008; Emerson, Fretz and Shaw 1995; Taylor and Bogdan 1998), during which an extensive in-depth combing of the data was used to find significant terms, phrases, or themes. After the open coding phase, a more limited set of codes was used to conduct another round of coding (Emerson, Fretz and Shaw 1995; Taylor and Bogdan 1998). Focused coding allows the researcher to pull the most significant ideas from the data to develop into concepts or themes, with the goal of explaining theoretically what is happening in the field. Although the creation of concepts and themes to explain the context is a classic technique of the grounded theory methodology (Charmaz 2006; Glaser and Strauss 1967), using it in the context of extended case method allows for better critique, revision, and modification of the existing

outpatient interview. The cost of transportation to the public clinics and hospitals was cited as a barrier keeping very poor people from receiving the health care they needed.

theoretical framework. The texts were analyzed through a critical discourse analysis, as this type of discourse analysis focuses on how power is used to construct social problems and social inequalities (van Dijk 1993).

Methodological Challenges

Triangulation of Data

Triangulation refers to the use of two or more data collection methods or sources within one study to gain fuller, deeper understandings of the findings and themes from the data (Taylor and Bogdan 1998). Triangulation also helps to establish the validity of a study's findings by looking to answer the same question(s) using various sources, methods, and researcher perspectives (Farmer et al. 2006). Exploring an empirical issue through different methodological approaches also helps to illustrate what may be missing through the utilization of only one approach, or it may bring up more questions to explore. Denzin (1978) elaborated on four types of triangulation, including methodological (the use of two or more data collection techniques), data (involving multiple data sources or respondent groups), theoretical (using several theoretical lenses to view the findings), and investigator (involving two or more researchers to collect and analyze the data).

Various methods of triangulation were utilized in this project. As a dissertation project, investigator triangulation was not possible. However, each of the three remaining forms of triangulation as explained by Denzin (1978) were utilized. Methodological triangulation was achieved by collecting data through three avenues: observations, interviews, and discourse collection/analysis. Data triangulation was achieved by not only collecting discourses from multiple sources but also by including two hospitals in the research design and by having three respondent groups (patients, providers, and outsiders). Finally, theoretical triangulation will be

demonstrated throughout the dissertation. Although the primary theories for analysis include biopolitics and biological citizenship, with regards to some of the findings these theories were found to be inadequate; as such, the theories were modified through extended case method and other theories are utilized as well.

Language

The official language in Chile is Spanish. As a native English speaker who had taken some Spanish classes from middle school through undergraduate education, I continued to enroll in university-level Spanish courses leading up to the departure for fieldwork. These one-semester courses include oral Spanish, Spanish linguistics, and Spanish grammar. To acculturate to Chilean Spanish and to increase fluency, I took intensive Spanish classes in Santiago for one month before starting fieldwork; these classes met for five hours a day, five days a week and often included an additional two to three hours a day of extra lessons. Throughout the data collection process I continued to meet with a language instructor from the school for one hour a day, once a week. To ensure my interpretations of information during interviews, follow up questions were used so that participants could elaborate on what they meant. Additionally, if problems of interpretation arose after interviews, observations, or from texts, native Spanish speakers were consulted to double-check on perceived meanings.

Ethics

The first ethical challenge of this project was informed consent. During the preliminary site visit, I was warned by several contacts that people in Chile might be hesitant to sign their name to something because of the potential legal ramifications of doing so. Approval was received from the University of Illinois (UIUC) Institutional Review Board (IRB) to conduct interviews using oral informed consent. The bioethics committees at both hospitals, however,

preferred that written informed consent letters be signed by interview participants, so this procedure was followed and signed consent forms were kept in a file folder in my apartment while in Chile, and in a locked file cabinet in my university office in Urbana, where no other person could access them. On very few occasions did any interview participants have a problem signing the form. The oral informed consent procedures approved by the UIUC IRB were used with interview participants in the outsiders group.

A second ethical challenge for this project was confidentiality. Interview participants were referred to the project by the attending mental health professional after a determination that each participant was capable of being interviewed for the project. The heads of psychiatry at both hospitals reviewed the project before sending it to their respective bioethics committees, and were aware that one stipulation of interviews was that the identities of the patients who were interviewed for the project would not be revealed to anyone, nor their responses reported in an individually identifiable way to any mental health professional (or other person in general). On occasion when some of the mental health professionals asked whether interviews had been conducted with particular patients, they would only be told whether that patient had been recommended for an interview but not whether the patient had provided one. In *Hospital del Salvador* there was brief confusion over the signed informed consent letters, as the head nurse of the in-patient ward requested that a copy of the signed letter be kept in the patient file. The terms of the project as approved by the bioethics committee at that hospital were discussed with the head nurse and the signed letters were not kept in the patient files.

While the last major ethical issue, the presentation of self as a researcher was perhaps one of the more complex topics. For example, in the observations I would shadow the doctors as they interacted with patients to ensure that my presence was not inhibiting their ability to provide

medical services, as well as to ensure that certain patients were capable of providing interviews for the project. At *Hospital del Salvador* I was asked to wear a white doctor's coat during the observation period in the in-patient ward, just as the psychiatrists and medical students wore. Doing so allowed me to be less obtrusive during some of the larger patient interviews featuring one patient and eight to twenty mental health professionals. However, wearing a white doctor's coat in this setting also aligned me with psychiatrists and perhaps would have communicated certain messages to the patients about my perspectives, objectives, and expectations on interactions between myself and the patients. To combat this, before each patient interview and sometimes during observations, I introduced myself as a sociologist and researcher, careful to mention that I was not a psychologist or psychiatrist.

Conclusion

In summary, this chapter has provided a detailed description of the methodology for this dissertation project. Ethnographic methods were employed, including approximately 450 hours of observations and 80 interviews, as well as discourse analysis, to explore individual, national, and global constructions of depression. Utilizing extended case method, the findings were analyzed through the use of biopolitics and biological citizenship as guiding theories to be modified to better fit the empirical world. The psychiatry wards of two hospitals in Santiago, Chile were the primary sites of data collection and generating interview participants, although snowball and convenience sampling also helped to procure the "outsider" interview participants. In total, 80 interviews were conducted and 47 texts were collected. Transcripts, fieldnotes, and texts were analyzed in accordance with the norms of qualitative data analysis, drawing somewhat from grounded theory techniques, which include multiple rounds of coding as well as theme and concept development. It is the intent of this study to contribute to the growing field on global

mental health through providing a less deterministic and more holistic view of how mental health knowledge is ascertained or formed and what that knowledge, coupled with personal experience, means for individuals within a certain society.

CHAPTER 3: CHILE

Chile was chosen as the site location for this project because of its successes with the MIND Project, as claimed by the WHO, which include primarily the creation of legislative protections for people who suffer from mental illnesses. Chile provides a unique opportunity for this research because of its sociopolitical and economic history and because of its involvement in global aid programs, which has spanned over 60 years (Taylor 2006). The policies put in place and the reforms that happen in Chile are seen as integral global models for the rest of the world. To understand this site in context, we must explore the contemporary sociopolitical historical context, including the Pinochet dictatorship, the structure of the health care system, and mental health specifically. Each of these areas will be discussed in this chapter.

Chile: *Sur del Mundo* / South of the World

In 1541, Pedro de Valdivia founded the city of Santiago long before the country had been established (Rector 2005). The indigenous Mapuche people attempted several times, almost successfully, to destroy the colonies built near what is now downtown Santiago. Colonized by Spain, Chile had a Spanish population of 25,000 by 1700. It was not until 1810 that Chile had its first national government, although over a dozen towns had formed in the meantime. Within a year, the new government declared free trade, which accelerated the flow of goods between Chile and other countries. Independence from Spain was declared in 1818. Significant numbers of German immigrants settled in southern Chile during the 1850s.

In 1948, Chile was the recipient of the first ever World Bank loan (Escobar 1995; Taylor 2006). Chile was the first country in the world where a neoliberal project was established. Neoliberalism in Chile was focused towards restructuring “the relationships and institutions through which capitalist society is reproduced materially, politically, and ideologically” (Taylor 2006: 6) to change the connection between state and society. Ultimately, this will end in social institutions oriented towards strengthening the power of the market to mold citizens’ participation. What this indicates, according to Taylor (2006), is a change in power relations. International aid, such as that which came from the World Bank, was meant to capture the lower classes in Chilean society to involve them in capitalism. These initiatives ended in an extension of the reach of the state and in life as increasingly political.

Today, Chile has a population of just over 17 million people (Minoletti 2012). Almost 90% of Chile’s population lives in urban areas, and 40% live in Santiago and the surrounding metropolitan area. The indigenous Mapuche make up nearly 5% of the overall population (Richards 2010). Although income inequality has historically been high in Chile, in recent years it has decreased slightly (from a Gini coefficient of 55.2 in 2000 to 51.8 in 2006) (Gasparini, Cruces and Tornarolli 2011). The Gini coefficient in 2009 was 52.1 (WB 2014) and in 2011-2012 was 0.49, making Chile country with the highest level of income inequality among OECD nations (OECD 2011).

Before, During, and After the Pinochet Era (1973-1990)

Political parties in Chile are split into two groups, *Concertación de Partidos por la Democracia* (liberal or left) and *Alianza por Chile* (conservative). *Concertación* parties include the Christian Democrats, the Party for Democracy, the Socialist Party, the Radical Social Democratic Party, and Independents, while *Alianza* includes the National Renewal Party, the

Independent Democratic Union, and Independents. Prior to the dictatorship, *Unidad Popular* (Popular Unity) was an alliance between Socialists, Communists, and Radicals that was created in the 1940s when Allende became the leader of the Socialist Party; *Unidad Popular* fought for the nationalization of industries like copper mining as well as expansion of social programming such as public housing, health care, and education (Rector 2005). Allende sought to socialize Chile through democratic means (Rector 2005) during a time when the ruling elite was able to direct national resources to meet their own needs (Petras 1969). Economic development up through the 1960s had been uneven across the country, at the expense of the poor; income inequality has been a persistent feature of Chilean society and continues today. Income inequality grew through the 1950s; the lower and middle classes, from 1953 to 1959, experienced a loss of their share of the national income by five and one percent (respectively), as well as experiencing a 1% loss in absolute income while the upper classes gained in share of national income by almost 6% and their absolute incomes increased almost 30%. From 1954 to 1961, the minimum wage decreased by nearly one-quarter and by 1961 almost half of the workers in Santiago made minimum wage or less (Pinto 1964).

Through the 1960s the political system in Chile was relatively stable, with democratic elections to decide upon each succeeding president. This was due in large part to the control the upper classes had over government, as a unified bloc utilizing economic organizations and industry ties (Petras 1969). “While brutalizing the lower class through disregard of its basic health and nutritional needs, the elite has effectively socialized the middle-class leaders of insurgent groups so that they accept the norms of civility and the civic virtues of reciprocity, negotiation, compromise, and moderation” (Petras 1969:353). The middle and upper classes in Chile were strongly anti-socialist throughout the 1960s.

The United States donated \$20 million to Eduardo Frei Montalva's campaign in 1964 so he would defeat Allende (Burbach 2003). The CIA published false reports about Allende and *Unidad Popular* closer to the election, and American corporations also contributed to anti-Allende campaigns to the tune of over \$200 million. Salvador Allende finally won the presidency on September 4, 1970 in his fourth candidacy, with just over 36% of the vote (Haslam 2005; Sigmund 1976), against three other candidates (Velasco 1976). Allende's victory was an important global historical event as it was the first time in world history that a Marxist politician had been freely elected as the head of a national government (Valenzuela 1976).

At the time of Allende's election as president, Chile was experiencing a stagnant economy and rising inflation (Falcoff 1982). Allende attempted to stimulate the economy through the nationalization of major industries including copper and banking (Roberts 1998; Sigmund 1976). Under Allende's government, social programs were expanded to make housing more affordable and to make medical care more accessible (Taylor 2006). As a result, health indicators improved including a decrease in infant mortality (Rector 2005). School enrollment was up and unemployment rates dropped 22% from 1970 to 1973. Table 2 below, taken from a 1980 World Bank report (WB 1980), shows the expenditures for social programs during Allende's time as president (Collier and Sater 2004).

	<u>1965-1969 average</u>	<u>1970</u>	<u>1971</u>	<u>1972</u>	<u>1973</u>
<i>Health</i>	139.4	154.2	211.6	247.8	237.2
<i>Education</i>	281.9	362.0	473.2	524.2	354.9
<i>Housing</i>	133.7	108.6	229.0	228.3	229.9
<i>Child Assistance</i>	0.3	0.7	0.6	0.8	0.7
<i>Social Assistance</i>	6.9	7.8	8.4	10.6	5.3
<i>Social Subsidies</i>	0.8	1.9	1.5	0.8	0.3
<i>Total</i>	562.8	635.2	924.2	1012.6	828.5
<i>% of total expenditure</i>	32.2	28.9	33.5	34.3	21.6

Table 2: Expenditures for social programs, 1970-1973 as compared with 1965-1969 average, in 1976 US dollars. Chart from Collier and Sater (2004:331) with information from World Bank (1980).

Intolerance for the “*via chilena al socialismo*” (Chilean route to socialism) grew among the upper classes as society became increasingly politically polarized. The United States withdrew large amounts of funding to, as Nixon wanted, “make the economy scream” (Klein 2007), and the only remaining funding was directed to the Chilean military (Sigmund 1976). Lines of credit were no longer extended from the US to Chile, where during previous presidencies such funding provided \$220 million (Goldberg 1975). Chilean government efforts to make food more affordable for the poor through subsidization were undermined by elites who sold their goods on the black market instead of to the government, and many food items became

scarce. Class-based protests and demonstrations against the government became increasingly common and political tensions were high (Sigmund 1977).

On September 11, 1973, General Augusto Pinochet Ugarte led a military attack on *Palacio de la Moneda*, the presidential palace in Santiago, with \$10 million in support from the CIA (Burbach 2003). Allende was notified at 6:20 am that the port city Valparaíso had already been shut down by the navy, and by 8:00 am Concepción, a city south of Santiago with a large concentration of leftists, had been taken over as well (Sigmund 1977). Allende gave his final address over Radio Magallanes at approximately 10:00 am (Policzer 2008), expressing his disappointment in the military coup, thanking his supporters, and wishing for justice (Skidmore, Smith and Green 2009). After having refused secure transportation out of the country and ordering his cabinet to flee, President Allende shot himself at his desk in the *Palacio* while it was under attack (Haslam 2005), being hit by eighteen rockets from fighter bombers in a twenty minute period, and then stormed by the military (Sigmund 1977).

The military coup of 1973 marked a new era in Chilean history. Augusto Pinochet seized control over the government with the plan to squash socialist and communist remnants of Salvador Allende's presidency and reconstruct Chile as a completely capitalist society. Under advising from Milton Friedman at the University of Chicago, Pinochet enacted several economic "shock treatments" to achieve "the most extreme capitalist makeover ever attempted anywhere" (Klein 2007). These efforts included defunding social programs, providing tax cuts, and privatizing nearly every aspect of society, including industry, health care, and education. "Friedman predicted that the speed, suddenness and scope of the economic shifts would provoke psychological reactions in the public that 'facilitate the adjustment'" (Klein 2007:8). Chilean economists trained at the University of Chicago (the "Chicago Boys") were expected to help

with social reforms that would advance neoliberalism throughout seemingly every aspect of Chilean society (Rector 2005; Taylor 2006; Valdés 1995). Neoliberalism is a political ideology valuing restricted government, little social support, and positing that through capitalism poverty will be reduced and prosperity increased (Antonio 2007). The hope of spreading neoliberalism in Chile was through the idea that reshaping society by increasing the role of the market could fundamentally depoliticize life. The Chicago Boys recommended a plan of action including “creative destruction,” which is the immense scaling back or elimination of social services in order to let the market take over society and social relationships (Taylor 2006). By 1975 there was a significant decline in funding for social programs, to levels near or worse than ten years prior (WB 1980). These are elaborated in Table 3.

	<u>1965-1969 average</u>	<u>1974</u>	<u>1975</u>
<i>Health</i>	139.4	190.7	133.4
<i>Education</i>	281.9	381.3	289.1
<i>Housing</i>	133.7	172.8	70.0
<i>Child assistance</i>	0.3	4.1	3.4
<i>Social assistance</i>	6.9	5.1	5.1
<i>Social subsidies</i>	0.8	2.0	8.9
<i>Total</i>	562.8	756.1	544.7
<i>% of total expenditure</i>	32.2	27.6	29.4

Table 3: Comparison of expenditures for social programs from 1965 and the mid-1970s in 1976 US dollars. From World Bank (1980:165).

The abrupt and violent structural changes to Chilean society during Pinochet’s time were made to be successful by the military regime through massive political repression of those

believed to be opposed (Becker et al. 1990; Klein 2007). That is, communists and socialists, real or suspected (as well as their supporters and families), were collected by the military to be physically, verbally, and psychologically tortured and/or killed in the name of Pinochet's economic plan (Becker et al. 1990). Within the first few days of the Pinochet dictatorship, up to 1,500 people were estimated to have been killed (Valdivia Ortiz de Zárate 2003). By December 1973 it was reported that 2,800 civilians and 700 members of the military had been killed (Haslam 2005). In 1996, six years after the end of Pinochet's rule, the National Commission for Truth and Reconciliation released a 460-page updated version of its 1991 report defining torture and detailing who was killed by the military or known to have "disappeared" during the dictatorship (CNVR 1996). According to this report, almost 3,200 people were executed and almost half of them were not socialists or communists (CNVR 1996; Valdivia Ortiz de Zárate 2003). Other reports estimate 3,500 people were killed (Haslam 2005). Tens of thousands more were tortured. Many were interned, tortured, and/or killed at two makeshift detention camps in Santiago: one at the national soccer stadium, and the other at a converted private residence called Villa Grimaldi where the smell of the rose gardens haunted survivors long after their release.

Despite the efforts to depoliticize life through neoliberalism, the working class fell entirely into poverty, prompting social unrest and upheaval (Taylor 2006). The government's response was to reinstitutionalize society through the use of state-sponsored welfare services which would allow the state to shape social reproduction. The Pinochet dictatorship aimed to socially map those in poverty in order to regulate and depoliticize their condition of poverty. This sort of logic dominated Chilean policies and programs for the next thirty years. Targeting those in extreme poverty had the effect of stigmatizing and alienating people from society rather than fostering their engagement in society (Constable and Valenzuela 1991; Taylor 2006).

A significant change to Chilean society during this time was suspension of strong cultural beliefs in Chilean exceptionalism. Regardless of political party, Chileans had long felt their country was unlike any other (Haslam 2005) because of strong political parties and democratic government (Petras 1969). The dictatorship showed to many that Chile was not unlike its South American counterparts such as Argentina, Uruguay, and Paraguay, who had also fallen to dictatorships.

A new constitution was approved in 1980 which established the terms of presidency as eight years and called for a plebiscite to be held by 1988, the results of which shocked Pinochet as Chileans voted against him (Borzutzky and Oppenheim 2006). In the 1990 election, the people elected Patricio Aylwin, a *Concertación* candidate, effectively ending the dictatorship. Chile's *Concertación* government in the post-Pinochet era adopted a "growth with equity" stance which depends on social institutions to correct the failures of the capitalist market while also nurturing social inclusion (Taylor 2006). It was not until the election in 2010 that a candidate outside of the *Concertación* won the presidential election (Morales Quiroga 2012).

Chile in Context: Latin American Psychiatry and Mental Health

Although early beliefs about mental illness in Latin America were based on religious faith, European influences on Latin American psychiatry began in the early 1900s, including the introduction of Freudian texts as early as 1915 by Gregorio Bermann of Argentina. Biological treatments for mental illnesses were adopted across parts of Latin America beginning around the 1930s (Alarcón and Pérez-Rincón 2010). Although influenced by western psychiatry, including use of diagnostic measures and training of professionals, Latin American psychiatry maintains its own identity, making unique contributions in several areas including folk psychiatry and culture-bound syndromes. Latin American contributions to the psychiatric literature have doubled since

1998, although research has been concentrated in Brazil, Mexico, Argentina, Colombia, and Chile (Gallo and Tohen 2010). The 1990 Declaration of Caracas, from the Regional Conference on the restructuring of Psychiatric Care in Latin America (convened by PAHO/WHO), called on the governments of Latin American countries to restructure psychiatric care such that services would be provided in primary care, respecting the dignity and rights of patients including legislative protections, training based in community health care models, all for “successful development” of the region (PAHO 1991; Maass, Mella, and Risco 2010).

Latin America and Chile in particular have strong histories of social medicine – the understanding of health and illness as rooted in social and political conditions. A groundbreaking work in 1939 from then-Minister of Health Salvador Allende, *La Realidad Médico-Social Chilena* (The Chilean Medico-Social Reality) examined numerous health problems facing the Chilean people, arguing that the social conditions of poverty and underdevelopment generated (or at the very least, majorly contributed to) health problems such as tuberculosis, sexually transmitted diseases, and infant mortality. As illness manifests from social conditions, from a social medicine perspective the solutions are social as well. Political violence and repression in Argentina, Chile, Colombia, and Brazil squashed portions of the social medicine movement as leaders lost their jobs, were forced into exile, or were tortured (Waitzkin et al. 2001a).

The deinstitutionalization movement, meaning fewer beds in custodial psychiatric hospitals, has reached many parts of Latin America and the Caribbean including Chile, Brazil, Argentina, Belize, Mexico, Cuba, and Jamaica; at the same time, several countries have struggled to compensate by increasing resources in primary care (Razzouk et al. 2012). The WHO has worked towards deinstitutionalization in southeastern Brazil, advising for increasing

psychiatric care in general hospitals through community care models (Candiago et al. 2011).

Although the number of beds in psychiatric hospitals has decreased, general hospitals still need to increase capacity by 30-50%. Patients stay 200% longer in psychiatric than general hospitals (Candiago et al. 2011).

Comparisons across cities in Latin America and the Caribbean showed that elderly women had poorer health outcomes than men, including 50% higher prevalence of depressive symptoms for women (Zunzunegui et al. 2009). Women in Latin America are almost three times more likely than men to experience somatic symptoms associated with depression; across both men and women quality of life was significantly lower for those experiencing somatic symptoms (Muñoz et al. 2005). From a sample in Buenos Aires, depression was correlated with lower education, higher age, and recent stressors (Leiderman et al. 2012). Depression is more prevalent among lower socioeconomic groups in Costa Rica (Rosero-Bixby and Dow 2009). Using multiple measures to capture the prevalence of depression among the elderly in Peru, Venezuela, and Mexico showed that the DSM and ICD-10 criteria may not adequately capture all of the people experiencing depression. Many of the elderly with depression had not received treatment (Guerra et al. 2009). Indigenous populations in Ecuador, with high rates of depression, more often manifest somatic than cognitive symptoms, thus calling for attention to cultural and social factors influencing depression (Yusim et al. 2010). In Peru, people exposed to sustained political violence experienced long-term consequences such as post-traumatic stress disorder, anxiety, depression, and local expressions of distress even ten years after such exposure (Tremblay et al. 2009). In 2007 in Chile, depression was the fourth most common health problem treated through *AUGE*, behind hypertension, childhood respiratory infection, and

diabetes, and making up almost 7% of total treatments through the national insurance program (GdC 2007).

The Chilean Health Care System

Health and Health Policy in Chile

As previously mentioned, health has long been viewed in Chile through the perspective of social medicine (Waitzkin et al. 2001), that is, as the product of social, political, and economic conditions faced by the population. The first health program established in Chile was the *Servicio Médico Nacional de Empleados (SERMENA)* in 1942, a program for public and private sector employees. On the suggestion of senator Salvador Allende, the national health care program (*Servicio Nacional de Salud, SNS*) was implemented in 1952. The program achieved the eradication of polio, gaining control over tuberculosis in the country, decreasing infant mortality by over 75%, and increasing life expectancies by about fifteen years for both men and women (Azevedo 1998).

During the Pinochet era, the main themes of health care were decentralization and privatization. Twenty-seven regional health services were created which were more or less autonomous, and in 1980 there was a “municipalization” of primary care through the creation of community health centers (Azevedo 1998). *SNS* was renamed *Sistema Nacional de Servicios de Salud (SNSS)* (Labra 2002) under which the public health care system, *Fondo Nacional de Salud (FONASA)*, began in 1979 as a conglomeration of the past *SNS* and *SERMENA* systems. In 1981 the private health care system (*Instituciones de Salud Previsional, ISAPRE*) was created. Both *FONASA* and *ISAPRE* systems were established with the requirement that subscribers pay in 7% of their incomes. Upon the start of the democratically-elected Aylwin government in 1990, health care in the country was in bad shape. The “municipalization” of health care was only

partially achieved and public services had deteriorated severely. As a response, the government invested \$450 million (USD) in the health care system over the next five years to support completion of community health centers as well as working to alleviate inequalities through fighting poverty.

The current health care system in Chile is split between public (*FONASA*) and private (*ISAPRE*) health care (Schaeffer and Valenzuela 2008). About 70% of the population is covered by *FONASA* (Infante 2007). The private health care system which covers 17% of the population (Vargas and Poblete 2008), in which many claimed the “better” doctors and services were, is still seen as elitist and only for the very wealthy. About ten percent of the population has health care provided through the armed services and other social services, and a very small percentage pay out of pocket for private services (Becerril-Montekio, de Dios Reyes, and Manuel 2011).

Although there is a split between public and private health care, the current national health care program (Regime of Explicit Health Guarantees, or *AUGE*), secured access to services for 56 of the most common, or “priority,” conditions in Chile regardless of whether one is covered by private or public health care (Araya, Alvarado and Minoletti 2009)¹⁴. This program, which became law in 2004, includes several guarantees about treatments for depression. For instance, services and treatments are available for free or low cost to patients. The most someone would pay for depression treatment under the *AUGE* program is US\$75, even if hospitalization is required. Another guarantee includes the amount of waiting time to see a health care provider; under *AUGE*, a person experiencing severe depression must be seen by a psychiatrist or mental health specialist within 30 days.

¹⁴ By 2014, eighty conditions were covered by *AUGE*, including bipolar disorder.

Mental Health in Chile

The first psychiatric hospital, *Casa de Orates*, was established in Chile in 1852. Although attempts were made to initiate community-based mental health centers in the 1950s and 1960s, these efforts were shut down in 1973 under Pinochet and the leaders of the movement were treated in a similar fashion as perceived socialists (Minoletti, Sepúlveda and Horvitz-Lennon 2012). Chile lacked any mental health policies until 1990, which has been understood as symbolic of the prejudice and stigma that existed at that time against Chileans who experienced mental illnesses (Araya and Araya 1991). In part, the dearth of mental health policies or programs was due to the major restructuring of health care during the Pinochet dictatorship, a period in which health care was decentralized and privatized. In 1993 the first mental health unit was created in the Ministry of Health (Minoletti, Sepúlveda and Horvitz-Lennon 2012).

In 2001 the National Depression Treatment Program was introduced (Araya, Alvarado and Minoletti 2009), the first of its kind in a low or middle income country. The program has allowed diagnosis and treatment of depression to be expanded from the specialist psychiatry level to the level of primary health care, although more severe cases are funneled to providers in higher, more specialized levels of care. By 2009, of those treated for depression, 84% were handled in primary care clinics. The number of people under medical care for depression in Chile has increased more than six and a half times – from about 18,000 to over 275,000 people – within the first ten years (2001-2009) of the addition of coverage for depression in the national health care plan (Minoletti, Rojas and Sepúlveda 2011). By 2009 *AUGE* provided treatment to over 530,000 people with depression (Araya, Alvarado and Minoletti 2009).

The current mental health care system is comprised of three levels, increasing in potential treatment options and catering to more severe cases going up each level. The hope with this

system is that each progressive level of care will see fewer cases. Recent interventions, including the MIND Project, have aimed to increase access to treatments at the primary level. This primary level of care in Santiago is comprised of the previously mentioned community health centers (*Centros de Atención Primaria*) as well as community mental health centers (*COSAMs*), of which each neighborhood (*comuna*) typically has at least one. From the *Centros* or *COSAMs*, medical professionals refer anyone with more than a *leve* or mild case of depression to the second level of care. The second level of care is typically a hospital whose catchment area comprises several *comunas* or an area of the city. *Hospital del Salvador*, for example, is the primary hospital for the western *comunas* of Santiago. The most severe cases from around not only Santiago but the entire country would be referred to *Instituto Psiquiátrico Dr. Jose Horwitz Barak*, considered at the third level of care and suited for longer term stays (over one month).

In 1992, there was almost a 52% prevalence rate for mental illnesses in Chile (Florenzano et al. 1995). A 1995 study found a slight increase in prevalence of mental illness (53.5%), with a third of patients having two or more diagnoses (Florenzano et al. 1995). Although in 1992 only 4.6% of the population was diagnosed with depression, in 1995 depression was the most frequent diagnosis, constituting one-third of mental illness diagnoses. A higher prevalence of depression exists among women than men (Alvarado et al. 2012; Vincente, Saldivia and Kohn 2012). Sixty-six percent of the cases were treated with drugs including sedatives and anti-depressants, while one-third were offered psychotherapy, also known as a “talking cure.” A 2004 showed that mental health services were not accessible for the entire Chilean population, and that over 60% of people with a mental health problem were not treated (Valdivia et al. 2004). Stigma was a major reason for not seeking help with mental illness as over one-third of the sample listed fear

of stigma as a reason for not gaining help and another quarter abstained from receiving treatment out of worry that someone would find out.

More recently, Chile has been found to have the highest prevalence of mental illnesses of all of the Americas at 31.5%; almost a third of these cases are depression (Jirón, Machado and Ruiz 2008). In 2010, Chile had one of the highest rates (in the Americas) of Years of Life Lived with Disability (YLD) due to dysthymia and major depressive disorder, behind Mexico and comparable to Bolivia (Ferrari et al. 2013). Among children and adolescents, there is a 22.5% prevalence rate for any psychiatric disorder (Vincente et al. 2012). Major depressive disorder has a 5.1% 12-month prevalence rate among Chilean children age 4-18, and the prevalence is slightly higher among girls than boys. Nineteen percent of teenagers in Santiago have attempted suicide (Ventura-Juncá D. et al. 2010).

When viewed in global perspective, the lifetime prevalence of depression in Chile is lower than many other countries; the 12-month prevalence rate places Chile fifth in the list in Table 4, below Brazil, the United States, Colombia, and France.

	Lifetime	12-month
France	21	5.9
United States	19.2	8.3
Brazil	18.4	10.4
Colombia	13.3	6.2
Spain	10.6	4
South Africa	9.8	4.9
Chile	9.2	5.7
India	9	4.5
Mexico	8	4
Japan	6.6	2.2
China	6.5	3.8

Table 4: Prevalence of depression in selected countries, listed in descending order by lifetime prevalence. Information about Chile was drawn from Vincente et al. (2006), while for the rest of the countries the information comes from Bromet et al. (2011)¹⁵.

However, evidence shows depression to be on the rise amongst Chile's population, with a growth in prevalence of depressive disorders from 4.6% in 1992 to over 9% in 2006 (Florenzano Urzua et al. 1995; Vincente et al. 2006; Vincente et al. 2002). Use of antidepressant medications in Chile, many of which are available through the *AUGE* plan, has skyrocketed over 470% over the twelve-year period from 1992 to 2004 (Jirón, Machado and Ruiz 2008). From 2004 to 2007 the number of new patients seeking treatment each year for mental illnesses went up almost 350%, primarily because of depression (Minoletti, Sepúlveda and Horvitz-Lennon 2012).

Conclusion

Chile's complex contemporary social and political history provides a unique and interesting backdrop for the current project. The economic "shock treatments" of the Pinochet era were meant to create psychological shocks as well, and the major economic and social restructuring of Chilean society over the past 40 years paired with intense political tensions has

¹⁵ As the Vincente et al. piece predates that of Bromet et al. by five years it is possible that the lifetime and 12-month prevalence of depression has changed in Chile, although more current data was not available at the time of this writing.

indeed caused a break from Chile's past. With the recent end of the dictatorship, structural and legislative adjustments, and the high utilization of mental health services in general and for depression, understanding how people see this exponentially increasing disorder becomes all the more important.

“We do not have on the one hand ‘knowledge’ and on the other ‘society.’” Latour 1987:200

“...the approach to a problem, the level on which the problem happens to be formulated, the stage of abstraction and the stage of concreteness that one hopes to attain, are all and in the same way bound up with social existence.” Mannheim 1936:278

CHAPTER 4: THE BIOPOLITICS OF POLITICIZED PSYCHIATRIC KNOWLEDGE

The objective of this chapter is to address the first research question: How are biopolitical goals reflected in the MIND Project? Along with an examination of biopolitics at the level of global psychiatry, this chapter will also provide an analysis of national level constructions of depression through both “official” psychiatric knowledge (i.e., those produced by the Ministry of Health) and popular constructions of depression in texts (e.g., books and readings for lay audiences about depression, produced in Chile by Chilean authors). Deconstructing knowledge and the ways that knowledge is put into action helps to show the underlying values, biases, and perspectives that are intricately bound together (Mannheim 1936, Jutel 2009), in this case, in the creation of discourse around psychiatric disorders. As categorizations of diseases, disorders, and illnesses are conglomerations of symptoms or traits socially decided to be undesirable and needing treatment (Jutel 2009), analyzing the construction of discourse and subsequent action plans around such disorders can reveal the dominant ways in which the conditions are seen to be problematic as well as the social values contributing to the classification of a condition as an illness. This chapter will walk through an analysis of global and national texts about mental health and depression, utilizing biopolitics as the guiding analytic framework.

Biopolitics

Biopolitics arose in Foucault’s work starting with the 1976 publication of the first volume of the *History of Sexuality* as well as his lecture of March 17 (as published in *Society Must Be*

Defended). As Foucault argued, biopolitics emerged out of 18th century liberal governments, that is, governments reorganizing actions around the idea of achieving maximum efficiency through inspiring in people critical reflexivity and self-regulation. Rather than government for government's sake, government took on a new meaning where there should be reason and rationale for governing.

Within this historical conceptualization of government, Foucault vaguely describes biopolitics as the use of power to frame human life in terms of biological problems affecting the population. Along with this description, Foucault argued that while biological problems were perhaps not the most deadly, they were persistent and chronic ailments to society which detracted from the nation's economic goals in requiring expensive remedies and by removing people from the workforce. At once, issues falling under biopolitical gaze are biological, political, economic, and scientific. Those conditions, illnesses, or diseases which had the most severe economic and political effects would become objects of knowledge around which government would look to define through the use of certain people deemed experts on health topics. Measures would be constructed as a quantitative gauge of the intensity of specific health problems to use as part of mechanisms and plans to assuage them.

Although Foucault does not explicitly outline components of biopolitics, from his writings on the topic biopolitics can be reduced to three main ideas¹⁶ which guide the analysis in this chapter:

¹⁶ These areas are similar to Rose & Rabinow's understanding of biopower as elaborated in Chapter 1, which outlines truth discourses, intervention strategies, and modes of subjectification as important elements. Foucault's original writings on biopolitics place much less emphasis on the ways in which biopolitical governance structures shape the actions of individuals than on the formulation of knowledge and the means by which that knowledge is acted upon, so for the purposes of this chapter the analysis follows the elements as articulated in this chapter.

1. *Construction of knowledge* of a problem as collective (i.e., referring to a population), scientific, biological, economic, and political;
2. *Articulation of knowledge* through measures and formulas to operationalize the issue and those enabled or empowered as knowers (experts); and
3. *Transformative mechanisms* which provide the means of turning knowledge into action.

The Texts¹⁷

Texts were collected from the World Health Organization and from the Chilean context, to explore global and national knowledge and conceptualizations of depression. Documents from the World Health Organization include the diagnostic definition of depression from the International Statistical Classifications of Diseases and Related Health Problems (ICD-10), pamphlets about the MIND Project, website information about depression and the MIND Project, Country Summary Reports on Chile, and other pertinent texts, totaling 12 items. From the Chilean national context 35 texts were collected to gauge national definitions and local understandings of depression, including newspapers, clinical treatment guides, popular books on depression for the general public, and pamphlets distributed by health care providers. The relevance of each text was assessed and only those with high relevance (23 texts: 11 global and 12 national) have been analyzed for this chapter. High relevance was a designation given to texts produced by the WHO about depression, Chile and mental health, or the MIND Project. It was also designated for texts produced within Chile by the Ministry of Health about depression

¹⁷ In this chapter I refer to texts by number to avoid confusion with cited references. The numbers assigned to each text have no meaning other than to denote a unique text and the texts were not numbered in any particular fashion. The list of texts and numbers appears in Appendix B.

and national health programs for depression, clinical treatment guides, and by Chilean authors for lay audiences about depression.

Texts were analyzed using grounded theory techniques, starting with open and focused coding as previously explained in Chapter 2. Traditional grounded theory research begins with the data and allows concepts and theories to grow organically from the data that is collected (Corbin & Strauss 2008, Glaser & Strauss 1967, Charmaz 2006). As this project is concerned with modifying the existing biopolitics and biological citizenship theories, the project follows extended case method as the methodological framework; however, data analysis began with open coding as in usual grounded theory approaches to allow for concepts to stand out. Focused coding entailed re-examining the data primarily for concepts from biopolitics, but also for ones that arose from open coding. Through the focused coding and analysis process, names of concepts from the original theory of biopolitics were defined using terms and important characteristics from the data. These definitions that come from the texts group characteristics to provide description and definition for concepts, as elaborated by Corbin & Strauss (2008). New concepts that came up during open coding were also pursued in this way through focused coding.

Mental Health Improvements in Nations Development: The MIND Project

Constructions of Knowledge

At the global level, depression exists not as one entity but as two general disorders: depressive episode and recurrent depressive disorder¹⁸. Either can be mild, moderate, or severe, and either can be with or without somatic and/or psychotic symptoms.

¹⁸ Included in the same section on mood disorders in the ICD-10 are bipolar affective disorder, manic episodes, persistent mood disorders such as dysthymia, “other” mood disorders, and “unspecified” mood disorder. As the focus of this dissertation is depression, these disorders have been excluded from the analysis.

“The individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatigability and diminished activity. Marked tiredness after only slight effort is common. Other common symptoms are: (a) reduced concentration and attention; (b) reduced self-esteem and self-confidence; (c) ideas of guilt and unworthiness (even in a mild type of episode); (d) bleak and pessimistic views of the future; (e) ideas or acts of self-harm or suicide; (f) disturbed sleep; (g) diminished appetite” (46).

The text continues to explain there are some important “somatic” symptoms as well, four of which should be present at once: “loss of interest or pleasure in activities that are normally enjoyable; lack of emotional reactivity to normally pleasurable surroundings and events; waking in the morning 2 hours or more before the usual time; depression worse in the morning;... definite psychomotor retardation or agitation...; marked loss of appetite; weight loss...; marked loss of libido.” Many of these symptoms relate to the inability of the body to perform its usual functions, primarily through “diminished,” “decreased,” “loss,” and “lack” in eating, sleeping, moving, sex, and mental and physical capacities. The MIND Project brochure (35) refers to mental illnesses as possibly neurological and as causing disability.

From these examples from the texts, we are able to discern one characteristic (or “property,” as Corbin & Strauss [2008] would call it) of the construction of knowledge around depression: it is biological. The collection of texts would define “biological” meaning that the physical body is understood as a machine with the capability to function, where depression works against those functions to disable or diminish the functioning of the machine (body) itself.

The defining of depression and mental illnesses as debilitating, disabling, and diminished concentration and activity allude to a reduction in the maximum capacity of people’s contributions to society through work as a productive enterprise. Many of the texts explained the economic aspects of mental illness: that through treating people with mental illnesses, “[t]hey will be able to work and rise out of poverty, provide their children with the right social and

emotional environment to flourish, participate productively in community life, and contribute to the economy of their country” (43). Depression specifically is clinically expected to cause “some difficulty in continuing with ordinary work activities” (46). Further, the ICD-10 posits that although inclusion of “social performance” may not be necessary to indicate the severity of depression, “[t]he extent of ordinary social and work activities is often a useful general guide to the likely degree of severity...” As noted in the MIND Project brochure, mental illnesses create “a devastating social and economic impact for individuals, families, and governments” (35). Individuals experiencing mental illnesses may become stuck in the “vicious cycle between mental ill-health and poverty,” where “poverty increases the risk of mental disorders and having a mental disorder increases the likelihoods of descending into poverty” (47). Thus, the WHO logic is that treating mental illnesses will simultaneously enable healthier and wealthier individuals: “Providing treatment for people with mental disorders will enable them to get a job, reduce their health care costs and help to create the conditions necessary for them to rise out of poverty” (47). This report, as part of the MIND Project, extrapolates from the financial contributions to and outcomes of mental illness for individuals to say that treating mental illness is necessary to meet goals of “health, development, or poverty reduction agendas” at both the national and international levels. Inherent in its name, the WHO’s MIND Project is immediately an economic one through its focus on national development. Countries are called upon to establish or expand mental health budgets to make treatments more accessible, and individuals are expected to follow such treatments, recover, and find paid employment as a service to national economic development. The WHO calls upon nations to calculate the costs of a national mental health policy and plan (41) and make cost-effective treatments more widely available

(43). Chile's national mental health plan and budget increases are part of what the WHO lists as accomplishments in their report on best practices (36).

From the collection of texts, "economic," refers to financial resources available to a person or nation, relating to well-being and development to both individuals and their countries. To individuals, "economic" would be a relationship between paid work activities (employment) and poverty where an individual being employed is equated with rising out of or not living in poverty, the ability to access health care, and "leading a productive life" by contributing to the national economy. For the nation, economics is about development and growth in income, both aided by treating mental illness, as well as monetary expenditures which includes the amount of the total yearly budget spent on health and mental health care.

Tied in with the economic properties of mental health and illness in the WHO MIND Project are calls for governments to develop and implement new or improved mental health policies and plans, particularly to protect the human rights of people who experience mental illness (35, 39, 43). People with mental illnesses are discriminated against (35), being "denied basic life opportunities given to other citizens" (43). One of the guiding values of the MIND Project is that "the rights of people with mental disorders are promoted and protected," along with the participation of those people "in the civil and political lives of their communities and countries" (35). The government has a responsibility to address the mental health needs of the national population in order to "optimize" outcomes towards mental health (35, 47), part of which includes addressing the human rights of people with mental illnesses (35, 42, 43, 47). The MIND Project brochure explains that the WHO can provide aid to countries to "create and implement national mental health policies, plans, legislation and services" (35). Aside from these assertions, the MIND Project constructs mental illnesses as political in their effects in that

mental illnesses are said to create “a devastating social and economic impact for individuals, families, and governments” (35). The “political” comprises a major component of the MIND Project, and can be explained as a conglomeration of policy, plans, and services to be carried out by actors on behalf of the national government to ensure equal opportunity and treatment of citizens regardless of differentiating characteristics, such as depression status. The “political” is implied to be at a national level through the WHO’s offerings to support countries, and through the consideration of those suffering from mental illnesses as having rights based on citizenship, a characteristic relating the individual to the nation-state.

By designating a framework for the management and prevention of mental illnesses, national policy about mental health “defines the vision for the future mental health of the population” (39). Governments working towards expanded and protective mental health legislation, according to the MIND brochure, are promoting “the mental health and wellbeing of the population” (35). Mental illnesses are constructed as a problem not only for individuals who face them and the governments charged with addressing them, but as a public health issue inhibiting the well-being of an entire population (34, 35, 38, 39). Although the WHO is a global organization, the level of “population” can be understood as people within the borders of a single country as the MIND goals relate to countries and national governments in taking charge of mental illnesses experienced by citizens. More specifically, “population” would be described by these texts as the total number of people in a pre-defined group, here as within the boundaries of national geographic space. Population numbers are used to calculate and assess various characteristics of certain subgroups, such as age, poverty, and psychiatric disorders. Interventions are explained as important to prioritize on the public health agenda, and mental health policy is explained as defining “the vision for the future mental health of the population”

(39). People within the population are also constructed as members of various communities; the “essential package” information explains that its purpose is to “develop policies and comprehensive strategies for improving the mental health of populations,” and to “assist the reintegration of persons with mental disorders into all aspects of community life...” (38). The strategies employed by governments to protect and provide services to people with mental illnesses are simultaneously meant to enhance the health and well-being of the entire population.

The last component of the construction of biopolitics is that the issue is defined as a scientific one. Analysis of the texts revealed “scientific” not to be a useful coding category; in three places (35, 40, 41) there were references to “evidence-based” practices, although how such evidence is collected or how depression is studied is not discussed in the texts. In the ICD-10, there was one mention that the “scientific status” of the grouping of somatic symptoms of depression as a syndrome itself is questionable (46). Instead, what was of major importance in the texts was the role of experts. Here, experts can be defined as transnational actors, people who have acquired specialized, legitimated knowledge through evidence-based studies or experiences who work with others to implement mental health strategies and technologies through workshops and consultancies. As experts are considered along with operationalization of knowledge, this will be explored further in the next section.

Articulations of Knowledge

As ways to operationalize an issue through calculated measurements, formulas, charts, and other means, articulations of knowledge take several forms at the global level. To begin, articulations at the global level include the relationship between mental health and economic factors such as poverty and national development.

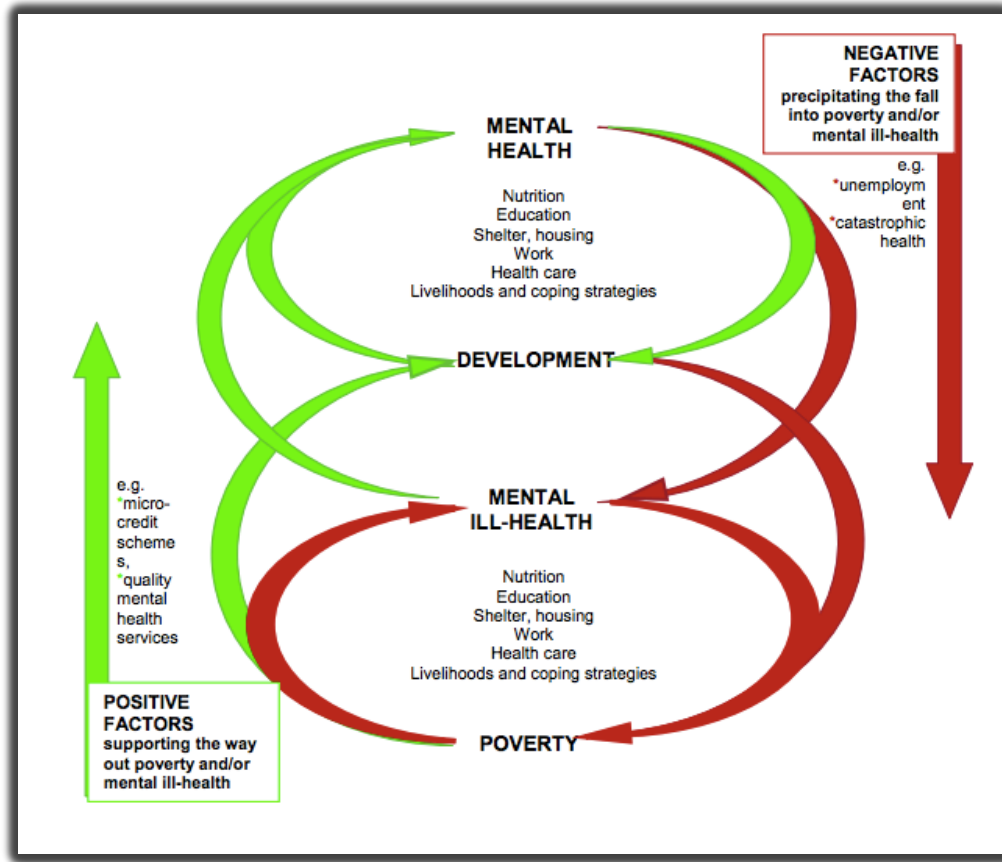


Image 1. “The Cycles and factors linking Mental Health & Development and Mental Ill-Health & Poverty,” WHO (47).

This diagram from a 2007 WHO report (47), as part of the MIND Project, provides a representation of the relationship between “Mental Health & Development and Mental Ill-Health & Poverty.” Nutrition, education, shelter/housing, work, health care, and livelihoods and coping strategies are all listed as contributing to mental and economic well-being. Negative factors that affect individuals— exemplified by unemployment and catastrophic health – lead a person to mental illness and/or poverty, which perpetuate each other. Positive factors which might “break the cycle” include quality mental health services and micro-credit schemes, both coming from a source or organization and provided to the individual. The image, using arrows between concepts, shows eight relationships between poverty, mental ill-health, development, and mental

health: two-way relationships exist between development and poverty, mental ill-health and poverty, and mental ill-health and mental health while a one-way relationship is presented from mental health to development. What is left out of the image are a two-way relationship between mental health and poverty and mental ill-health and development, as well as a one-way relationship from development to mental health.

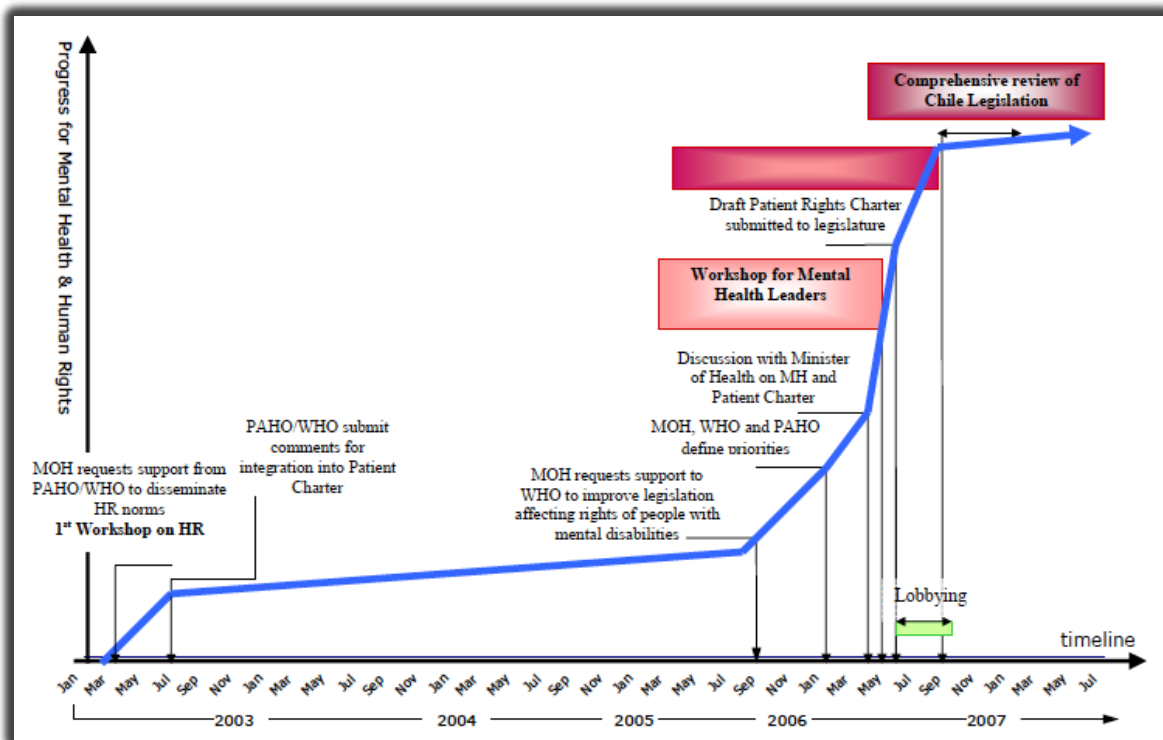


Image 2. Untitled, from WHO Chile Country Summary Report (34)

Articulations at this level of analysis also include perceived progress towards accomplishing a sufficient and appropriate system of mental health care and policy. The WHO, without quantifying “progress,” assesses its impact on the mental health context in Chile over a four-year period in the chart below which comes from the WHO’s 2007 country report on Chile. This chart recasts Chile’s recent legislative history regarding mental health by including only certain events seen to be significant by the WHO. Interestingly, the chart begins in March 2003

where the line originates from the x-axis, indicating the country had previously made no progress in mental health and human rights. The chart shows steady and slow progress over the period from July 2003 to September 2006, and the sharpest increase in the least amount of time is related to the workshop held in the country for mental health leaders – a direct intervention by the WHO that was facilitated by the WHO’s “network of experts” (35) or as Foucault would say, those empowered as knowledgeable about mental health. Although progress is not evaluated using numerical scores, the amount of change in the slope of the line at various points indicates which events the WHO believes to be most significant and which events are less significant. For instance, periods of communication back and forth between the Ministry of Health (as MOH in the chart) and the WHO/PAHO are constructed as making more progress than periods when the actual legislation is reviewed or changed. This chart provides a visualization of the WHO accomplishments in Chile but fails to take into consideration the country’s adoption of *AUGE*, the new health care program providing coverage to all citizens for some mental illnesses, in 2005. While the chart was only meant to capture WHO accomplishments it also gives the appearance that without WHO’s expert intervention Chile would not have had legislative accomplishments towards progress for mental health and human rights.

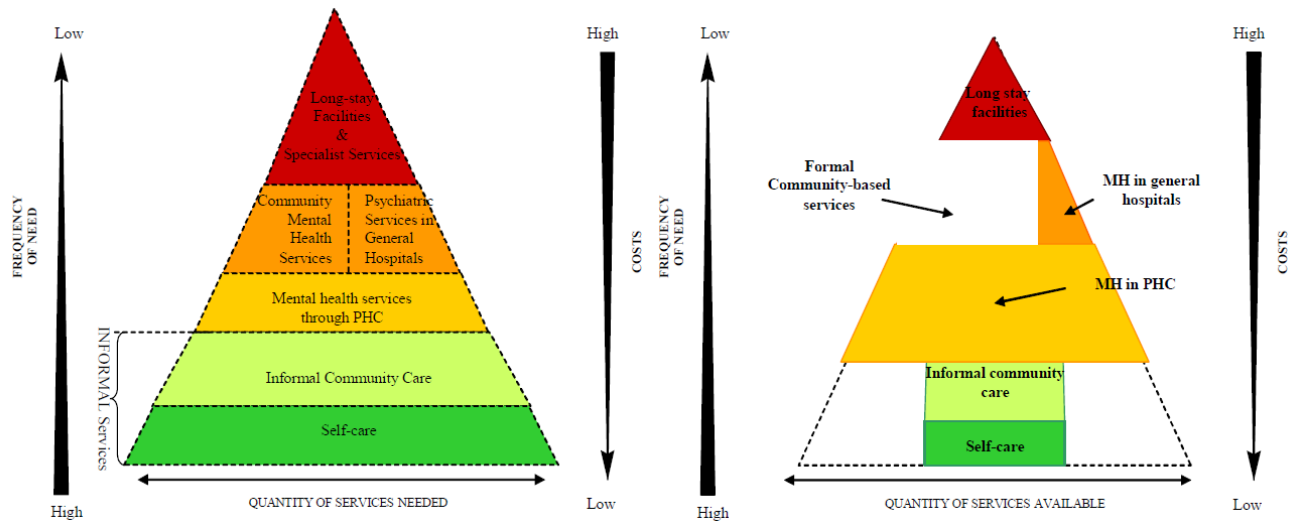


Image 3. “The global shape of mental health services: WHO Model vs Chile,” from WHO’s Chile Country Summary Report (34).

In the same country report assessing progress made in Chile, the WHO evaluates the structure of available mental health services in Chile as of 2006 (right) as compared with WHO’s ideal model of mental health services needed (left). The pyramid overtly represents quantity and costs of services as well as the frequency of need; what is left out of the picture but implied is that as one reaches higher levels in the pyramid, the mental health issues are expected to be more severe. Self-care makes up the base of the triangle as what the WHO represents as the most affordable and most easily accessible means of care, which is consistent with the biopolitical notion that individuals should and will regulate themselves in accordance with publicly available and socially desirable health standards. The outline of the triangle’s perimeter at the base aims to show that, when compared to WHO’s model, Chile’s mental health services are lacking in quantity of informal community care and self-care. As those two components of a mental health care system are informal, the government’s health system would begin at the middle of the triangle, at the yellow strip. By the WHO’s standards Chile’s mental health care in general

hospitals is lacking; formal community based services at the secondary level of care are altogether missing. The formal community-based services that do exist in Chile (COSAMs, *Centros Comunitarios de Salud Mental* or Community Mental Health Centers) are at the level of primary care. Overall, the image works to demonstrate where the WHO sees the Chilean system as over- or under-providing, in order to make clear what areas could be strengthened to reach the WHO's ideal. Comparing the Chilean mental health system with the WHO ideal sets up Chile to be evaluated by a global standard rather than through an assessment of whether the system meets the needs of people in Chile; being compared with the global standard opens the possibility of arguing that the people's needs are not met.

➡ **DEVELOPING A MENTAL HEALTH POLICY: STEPS 1 to 7**

- Step 1.** Assess the population's needs
- Step 2.** Gather evidence for effective strategies
- Step 3.** Consultation and negotiation
- Step 4.** Exchange with other countries
- Step 5.** Set out the vision, values, principles and objectives of the policy
- Step 6.** Determine areas for action
- Step 7.** Identify the major roles and responsibilities of different sectors

➡ **DEVELOPING A MENTAL HEALTH PLAN: STEPS 8 to 12**

- Step 8.** Determine the strategies and time frames
- Step 9.** Set indicators and targets
- Step 10.** Determine the major activities
- Step 11.** Determine the costs, the available resources and the budget
- Step 12.** Set up monitoring and evaluation processes

➡ **IMPLEMENTING POLICY AND PLAN: STEPS 13 to 19**

- Step 13.** Disseminate the policy
- Step 14.** Generate political support and funding
- Step 15.** Develop supportive organization
- Step 16.** Set up pilot projects in demonstration areas
- Step 17.** Empower mental health providers
- Step 18.** Reinforce intersectoral coordination
- Step 19.** Promote interactions among stakeholders

Note: Steps are a guide only, to be adapted at country level.

Source: *Monitoring and Evaluation of Mental Health Policies and Plans*. Geneva, World Health Organization, 2007 (Mental Health Policy and Service Guidance Package).

Image 4. “Overview of the ‘Stepped Process for Developing a Mental Health Policy & Plan,’”

WHO (41)

The WHO provides as part of its MIND Project a 19-step process for developing and implementing mental health policy and plan within a country, to be modified to fit each country's individual needs. The overview provided in this handout breaks down the pieces of creating mental health policy and plans so that actors within each nation can follow through, similar to cooking instructions through recipes. While this analogy is useful in general, the steps are not quite so simple: the first step, "[a]ssess the population's needs," provides no explanation of how the needs are to be assessed or what "needs" means in the context. "Empower mental health providers," among others, is equally vague.

Aside from the aforementioned articulations of knowledge comprised of how knowledge of an issue is operationalized, articulations of knowledge also include the person or people designated as experts on the topic. The texts on and about the MIND Project include references to an "International Network of Experts" (35, 40), included as a component of the project itself to provide support to participating countries. While not listed by name, this group of people are experts in "mental health policy, planning, legislation, service development and human rights" (35) who "have been trained in WHO's framework and methodology for working with countries" and assisted in creating WHO materials on mental health policy and services, for global distribution. These are the same people who facilitate workshops and training programs to share their knowledge with national representatives, and are available for short or long term technical support and advice to countries developing mental health plans and legislation.

Transformative Mechanisms

The WHO provides several means of transforming the structure of mental health services and care within countries, including the training program displayed as part of the progress chart above. Additionally, the WHO advocates for the use of their "Essential Package for Mental

Health Policy, Plan and Services” (38) which includes fourteen books, each covering a different aspect of mental health services (e.g., monitoring and evaluating mental health policies and plans, planning and budgeting, financing, improving access to psychotropic medicines). This package can be utilized as educational materials or to assist in creating new mental health policy consistent with global standards. This group of books constitutes a transformative mechanism because it is the tangible embodiment of psychiatric and policy knowledge put into a digestible format so that change will be enacted through their utilization.

Of the core components of the MIND Project, “Support to countries” (35) is another transformative mechanism wherein experts aid actors within countries by offering “technical advice and guidance to countries, while at the same time assisting... to build and develop national capacities.” This support may entail helping to answer questions about mental health in the country, providing an analysis of the mental health system, or by running training workshops. The official WHO MIND training program is a 2-4 day workshop for participants to learn about general concepts in mental health policy development and apply those concepts to their own national context. The workshops utilize small group activities and workbooks with case studies to problem-solve.

On the website of the MIND Project several training opportunities are included as means of putting mental health knowledge into action. The website includes brief descriptions of three educational programs in mental health topics (law & human rights, and policy & services) as distance learning opportunities, as well as a set of eight modules in a series entitled “Helping People with Mental Illness” to train community mental health workers about various aspects of mental health and illness. These modules were not analyzed as part of this chapter as they were not created nor endorsed by the WHO, although their presence as linked on the WHO website is

significant to mention as the modules represent one transformative mechanism (or eight, taken individually) presented by the organization.

Depression at the Chilean National Level

Constructions of Knowledge

At the national level, constructions of depression utilize diagnostic criteria from both the ICD-10 and the Diagnostic and Statistical Manual of Mental Disorders (DSM). The literature from the Ministry of Health focuses on depression, whether mild, moderate, or severe but also includes information about dysthymia and bipolar disorder. The grouping of texts at this level include clinical treatment handbooks from the Ministry of Health, information about depression from the Ministry of Health website, books about depression written by Chileans and publicly available in bookstores, a pamphlet from an advocacy group, and newspapers.

“One must understand depression as a psychosomatic illness: like alopecia areata, hypertension, asthma, and so many more” (7, pg. 26). Depression as biological, defined by this grouping of texts, means viewing depression as a grouping of signs or symptoms of the body, brain, or mind, determined in part by genetic predispositions and changes to chemicals in the brain (7, 9, 12, 18, 45), treated with different medications (fluoxetine, amitriptyline, and/or others) depending on the assessed symptoms¹⁹. “We are not sad, nor sleepy, it’s only that we have a high fever” (7, pg. 51). The first chapter of *Enfermedad Depresiva: Guía para el paciente y la familia* (Depressive illness: Guide for the patient and the family, 1) discusses neurobiological causes of depression, including alterations to genes, the hypothalamus, the

¹⁹ Psychotherapy is also included as a potential treatment, seen as more useful for milder forms of depression. It is not included in the definition of ‘biological’ as it is not conceptualized by the authors of the texts as a treatment that engages with or acts upon a one’s biology; it would be seen as a “social” treatment because of the emphasis on a person’s talking or sharing with the therapist about their own lives rather than receiving intervention upon the person’s physical body.

hippocampus, and the noradrenergic system as well as biochemistry and the neuroendocrine system. “He who would like to understand what depression really is today must turn to learned books, must lose himself in classifications and dendrites, in deep biochemistry, in precursors and monoamines²⁰” (7, pg 11). Seven distinct chapters in *Depresion: Clínica y Terapéutica* (Depression: Clinical and Therapeutic, 9) discuss various pharmacotherapies, including tricyclic and tetracyclic antidepressants, SSRIs, and electroshock therapy. Depression has forms that are “hidden” by physical symptoms (1, 12, 45). Other health conditions can make someone more prone to developing depression (7, 12, 18, 45). In many places, depression is explained in terms of the disability it causes (12, 18, 45), which is understood as the lowered or minimal functioning of people in their social and work lives.

Impaired functioning due to depression is often cited with reference to work or labor activities (12). Depression is seen as causing “functional limitations” for people at work, including lessened productivity and work absenteeism (12). One symptom of severe depression, according to the clinical treatment guide, is that the individual will have “a very pessimistic idea with respect to their economic future, feeling that there is no exit” (12). In this way, those who are stuck in poverty and feel they can do nothing to better their circumstances already meet one criterion for the illness. Along with these individualized ideas of work, labor, and finances, defining the “economic” also refers to the costs of depression primarily to people other than those who are diagnosed (1, 12). Costs are categorized into “direct,” meaning immediately associated with the diagnosis and/or treatment, and “indirect,” meaning through the impact of a person’s having depression on their surroundings, including lost productivity and worker absenteeism. Indirect costs are usually those borne by employers.

²⁰ Monoamines are a group of neurotransmitters including serotonin and dopamine (Delgado 2000).

Taken not at an individual level but an aggregate level, depression is seen as having large associated costs and widespread impact. Depression is constructed as a problem of the population throughout the national texts. Similarly to the global discourses, population would be defined as the people within the borders of the nation – in this case, Chile. For this group of people, the Chilean Ministry of Health declares that depression is a priority for the country as one of the most important public health issues (12); it is also explained to be a major global public health issue (45). Within the population, people may be grouped by a similar characteristic – age, gender, socioeconomic status, and race are some examples.

Because of the disability and economic costs caused by depression along with depression being a global public health issue, the Chilean government started the National Program for Diagnosis and Treatment of Depression (45). The government is responsible for providing some means of improving the health of people within its borders (45). The national program for the diagnosis and treatment of depression began in 2001 (45) with 100% coverage of costs. The government believes all people should have coverage “at the moment of demanding health care” (45). Thus, the political aspect of biopolitics here seems to represent a series of charges from the government: to itself, to provide coverage through health insurance, guaranteeing access to and payment for health services; to the healthcare structure and professionals, to make depression treatment accessible through expanding diagnostic procedures to primary health care; and to the individual dealing with depression, to seek health care when the individual needs it, to take charge of treatment both in action and through record-keeping. Part of the political aspect is also that treatment and policy are based on recent, reliable findings of clinical studies.

That treatment and policy are to be based on clinical evidence relates directly to depression being constructed in a scientific way. As part of a biopolitical construction of

knowledge, “scientific” can be defined here as investigations or studies about illnesses, including causes, distribution, and estimated prevalence within a given group which can range from particular (community) to groups by identifiable personal characteristics (race, age, sex, socioeconomic status). Use of similar methodologies and evaluation instruments allow for comparison across groups and time although the validity of instruments taken from one group and used in another is questioned. Results of studies are generalized to city, national, or global levels to make statements about the population. Health care programs are based on the most recent scientific studies and advancements. Using scientific studies, such as those in the neurosciences or genomic medicine (7), epidemiology or neurobiology (9), depression is understood as a syndrome (12), a group of signs and symptoms (12, 18) for which diagnosis was established using a base of standardized criteria (12). “One of the best available tools today to diminish the effects of stigma is scientific information...” (1, pg. 18).

Articulations of Knowledge

While the definition of articulations of knowledge remains the same at the national level – measures and formulas to operationalize depression and those people enabled or empowered as knowers – the content or types of measures and the “knowers” are different. Articulations at the national level work to identify people who have depression as well as those who have the potential to become depressed.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----

Factores Psicosociales de Riesgo	Si	No
Enfermedad física o dolor crónico		
Discapacidad psíqu. o física personal o un familiar*		
Abuso de alcohol y/o drogas		
Conflicto familiar severo (VIF)		
Vive sola(o)		
Parto reciente o vive con hijo menor de 6 años		
Escasa participación y apoyo en red social		
Pérdida de la madre (antes de los 11 años)		
Separación conyugal en el último año		
Muerte de familiar* en los últimos 6 meses		
Pérdida del trabajo en los últimos 6 meses		
Conflicto laboral severo (con daño de autoestima)		
Antecedente de suicidio en la familia*		
Episodio depresivo anterior		
Otro:		

Image 5. Assessing Psychosocial Risk for Suicide (12).

To begin, this chart comes from the clinical treatment guide for depression (12) as a way to calculate a person's risk of developing depression based on what have been determined to be psychosocial risk factors²¹. Each factor is listed in a row on the left; if a person has experienced or is experiencing the factor in question, a check mark is to be placed in the "Si" (Yes) column. Adding up the total number of "Si" (Yes) responses and marking that total number on the scale above the chart allows a health care professional to assess the patient's psychosocial risk of developing depression. The last row, labeled "Other," allows for other possible factors to be included as part of the calculation.

²¹ An English version of this table appears in Appendix C.

“Psychiatrists have been appropriated with the knowledge” (7, pg. 22). In several of the texts directed towards patients and their families, explicit instructions warn to follow the advice of the medical professional. Emphasis is placed on relying on a doctor, psychiatrist, or psychologist to provide information about how to overcome depression, especially regarding medications. “It’s very important to consult a doctor to begin appropriate treatment,” explains a pamphlet from a Chilean advocacy group (18). To get information about depression, one should consult their attending physician (7). “Share to the last secret with your therapist, and consult the specialist and not the internet about the type of treatment you have” (7, pg. 133).

Along with the messages instructing patients to see doctors as experts, a few of the texts (12, 13, 44) included instructions for how health care professionals should behave with patients to achieve optimum outcomes, including bedside manner, interview content and techniques, and ideal treatment recommendations based on patients’ symptoms.

Transformative Mechanisms

Like the articulations of knowledge, the transformative mechanisms are identical in at the level of general definition but differ through examples of how knowledge is turned into action. To begin, from the 2009 Clinical Treatment Handbook (44), this table displays potential treatments for depression in the column on the left along with the grade of recommendation in the right-hand column²². Drawing from research briefly elaborated in the handbook, this table provides a list of possible interventions for someone experiencing depression and is grouped into three categories: psychosocial interventions, pharmacological treatment, and electroconvulsive therapy. From recommending outpatient therapy, psychosocial group therapy, and psychoeducation to using selective serotonin reuptake inhibitors (SSRIs, a particular class of

²² The English version of this table appears in Appendix C.

antidepressant medication) as a first response for moderate or severe depressive episodes, each of the intervention suggestions represents one specific, individual transformative mechanism meant to act upon the depressed individual with hopes that through the action the person would transition to no longer being depressed. Texts from the Ministry of Health include pages of information about specific pharmaceutical drugs, for which symptoms they should be prescribed, and the side effects. Texts intended for lay audiences, such as the pamphlet by an advocacy group, give instructions to follow medical plans with pharmaceutical treatment, not to abandon the drugs when one begins to feel better, and also not to expect the drugs to serve as “magic bullets.”

Intervenciones psicosociales: La consejería, la intervención psicosocial grupal y la psicoeducación son recomendables para todas las personas con depresión, tanto en adolescentes como en adultos.	A
Indicar programa estructurado de actividad física en personas con depresión leve y moderada.	B
Indicar la participación de personas con trastornos depresivos en grupos de autoayuda.	B
Usar terapia cognitivo conductual o terapia interpersonal en conjunto con antidepresivos en episodios depresivos graves.	A
Tratamiento farmacológico: Utilizar como medicamento de primera línea, en episodio depresivo moderado y grave, un antidepresivo ISRS.	A
En adolescentes con depresión moderada, utilizar Fluoxetina en dosis inicial de 10 mg diarios, aumentando gradualmente hasta un máximo de 40 mg. al día, según respuesta.	A
Los antidepresivos tricíclicos se utilizan como tratamiento de segunda o tercera línea en depresiones refractarias, debido al alto riesgo de reacciones adversas y complicaciones graves en sobredosis.	A
En depresiones refractarias se debe optimizar dosis o cambiar antidepresivo, y/o potenciar con litio, liotironina o un segundo antidepresivo.	B
En episodios depresivos de trastornos bipolares, los estabilizadores del ánimo, como litio, lamotrigina y ácido valproico, están indicados como primera línea.	A
Los siguientes medicamentos están contraindicados en el primer trimestre del embarazo: paroxetina, benzodiazepinas, litio, carbamazepina y ácido valproico.	A
Terapia electroconvulsivante: La terapia electroconvulsivante (bajo anestesia), se recomienda para la depresión grave resistente a tratamiento en adultos y adolescentes.	A

Image 6. Recommended therapies to handle depression (44).

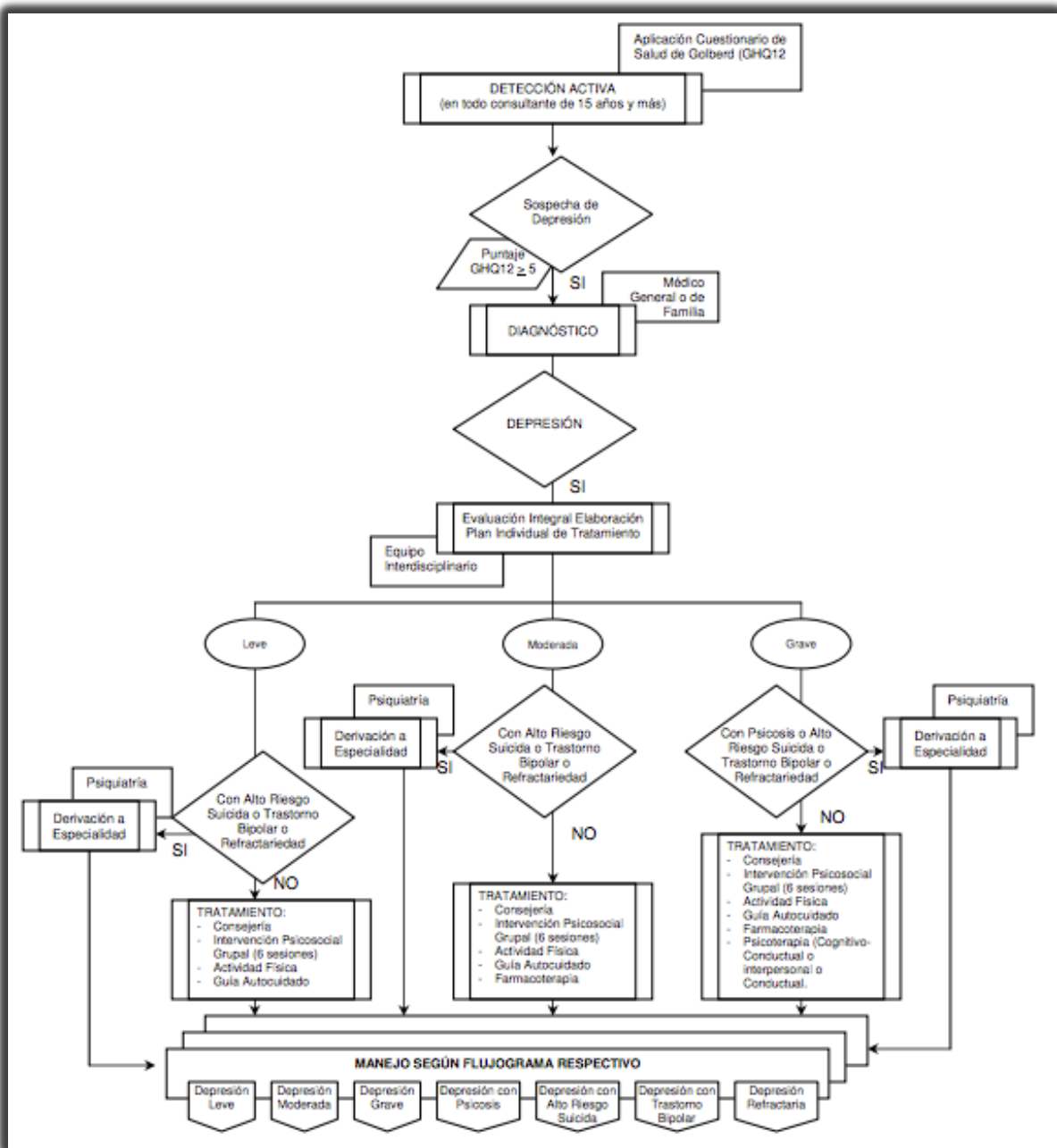


Image 7. “Flowchart for the Handling of the Person with Depression” (44).

Along with the graded recommendations for treatments, the Ministry of Health includes flowcharts for how to handle people with depression, that elaborate which evaluation tools and treatments should be used and at what point in the process along with who should be involved at

each step. To begin, health care professionals are to evaluate the patient using the GHQ-12 questionnaire, a 12-item survey meant to diagnose depression. After the diagnosis process is complete, the interdisciplinary team should determine the severity of the individual's depression, whether the person is suicidal, and decide either to treat the patient or refer the patient to a specialist. Such flowcharts represent transformative mechanisms because they show how psychiatric knowledge about depression, through its operationalization in tools such as the GHQ-12, should be used to effect change for the individual.

The group therapy guide gives many examples of transformative mechanisms. Grouped by activities for each week of a six-week program for people experiencing depression, many of the sessions include homework for participants to help them overcome depression. In session three, the focus is to plan activities, keeping attention on emotions and thoughts throughout the activity. The homework for participants after this session is to make three lists: activities in the past that made the person feel better, activities in the future that may help him or her feel better, and then to list old and new activities to do, including the day, time, and place of the activity. Week 4 asks participants to consider the various problems they see in their lives, while explaining that the problems that affect people most originate in family, work, finances, or health. The focus of the session is to teach participants how to identify the problems affecting them and divide them into small pieces to ultimately think of and analyze potential solutions to choose which one will best resolve the problem. This transformative mechanism operates by instructing people and then asking them to deconstruct complex social problems affecting individuals in their personal lives, such as "not having sufficient money for basic necessities," and "if your spouse is alcoholic." Sociologically speaking, this could be considered a reverse of

the sociological imagination (Mills 1959): taking public issues and making them private problems – and all of this to be managed medically through the treatment of depression.

Riesgo Suicidia	Síntomas	Evaluación	Acción
0	No hay peligro.	-	-
1	Perturbado emocionalmente.	Indagar sobre pensamientos suicidas.	Escuchar con empatía.
2	Vagas ideas de muerte.	Indagar sobre pensamientos suicidas.	Escuchar con empatía.
3	Vagos pensamientos de suicidio.	Valorar el intento (plan y método).	Explorar posibilidades de ejecución del plan. Identificar y contactar red social de apoyo de la persona.
4	Ideación suicida de riesgo leve o moderado y episodio depresivo leve o moderado.	Valorar el intento (plan y método).	Explorar posibilidades de ejecución del plan. Identificar y contactar red social de apoyo de la persona.
5	Ideación suicida de riesgo moderado y episodio depresivo grave; o ideación suicida de riesgo grave y episodio depresivo leve o moderado.	Valorar el intento (plan y método).	Derivar a especialidad psiquiátrica mediante referencia asistida (contacto directo con equipo de especialidad).
6	Ideación suicida de riesgo grave y episodio depresivo grave.	Permanecer con el paciente (para prevenir su acceso a los medios).	Hospitalizar.

(*) Adaptación de la tabla: "Resumen de los pasos en la prevención del suicidio", en: **Prevención del Suicidio. Un Instrumento Para Médicos Generalistas**, WHO/MNH/MBD/00.1, Ginebra, 2000.

Image 8. “Evaluation of the Risk of Suicide in People with Depression: Identification, Evaluation and Plan of Action” (44).

As part of the flowchart for how to handle people with depression, the Ministry of Health includes recommendations for actions to take based on assessed risk of suicide. The image above indicates a numerical risk for suicide, with higher numbers equating to increased likelihood of suicide along with a definition for each number, what to do to evaluate the symptoms, and what the health care provider should do based on assessed risk. This table combines articulations of knowledge through the definitions but includes which actions should be taken – from “listen with empathy” to “hospitalize.” This transformative mechanism, with the implied goal of stopping a death from occurring, operates at a base level through Foucault’s idea

of the general function of biopolitics as the making live of the population to lessen the potential for death to occur.

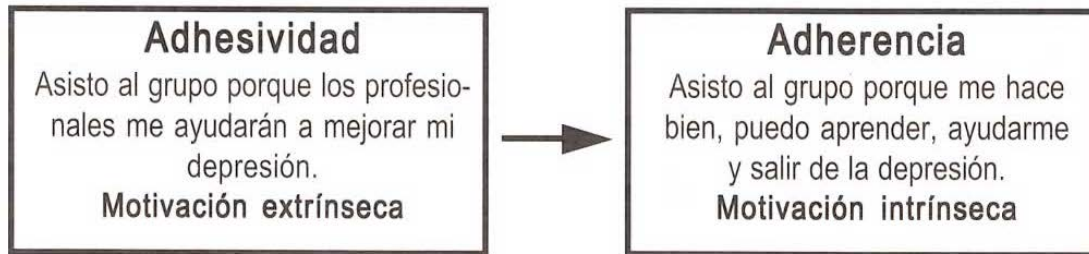


Image 9. Goal of group therapy: from extrinsic to intrinsic motivation (13).

The end goal of transformative mechanisms is well put in the image above, from the group therapy guide for clinicians (13). On the left, the box reads: “Adhesiveness: I go to the group because the professionals will help me to overcome my depression. **Extrinsic motivation.**” On the right, the box reads: “Adherence: I go to the group because it does me good, I can learn, to help myself and move on from depression. **Intrinsic motivation.**” Rather than going to the group because of the idea that someone else will help an individual get better, the purpose of the focus groups is that each patient who attends will develop a sense of personal responsibility in that each one is accountable for his or her own recovery, and will attend the group because of the desire to help oneself. This maps directly onto Foucault’s notion of self-regulation; that is, through biopolitical governance individuals will want to work for the common good and will act upon their own bodies or selves to align with what is determined to be healthy or biologically sound.

Comparative Biopolitics

Analysis of texts from both the global and national levels reveal that biopolitics is a fitting framework for evaluating the conceptualization, management, and use of depression

through mental health programs. In terms of the construction of knowledge, the texts representing the global level are focused on aggregated individual bodies as machines, where depression affects functioning, both physical and economic. National governments have to develop programs for all people within their borders, and nations are evaluated in their ability to recover the functioning of their own population as gauged by economic well-being. On the other hand, the Chilean texts explain depression as having to do with genetic predispositions and chemical imbalances of the brain, influenced by social factors and having effects on the individual and the people around them. In this way, the Chilean texts work through the molecularization of illness (Clarke et al 2010) – that is, the medical gaze focuses on smaller and smaller pieces internal to the body itself. Economic impacts in the national texts are seen as surrounding the individual and their work functioning, expanding to include the impact on employers. At both levels population has meant the group of people within the borders of the nation, although governments have different roles. In global perspective, governments are to provide health care and protection for all people in an equitable, non-discriminatory fashion; the national focus is that government will subsidize access to health care services for all people but also that individuals must seek and take charge of treatment. Generally, evaluating the groups of text for fit within biopolitics shows that the national level texts include all aspects of the construction of knowledge while the global texts fall short through lacking the scientific component. However, the global texts are closer to Foucault's definition of populations, capturing the idea of populations being aggregated individuals more so than the national level. Whereas the global texts focus on the development of mental health and depression programs by national governments, the Chilean texts are oriented towards informing clinicians in how to treat and individuals in how to overcome depression.

Articulations of knowledge which showcase the ways in which psychiatric knowledge is operationalized for evaluation and measurement purposes, among others, were present in both global and national discourses. For the global discourses, this meant illustrating the relationship between aggregated mentally ill people and the national economy as well as comparing ideal mental health programs with national realities. For the national discourses, articulations were centered around evaluating individuals for depression as well as their potential for developing it or its symptoms, including suicidal ideation. Experts – those enabled as “knowers” of psychiatric information – were present in both sets of texts as well, although the subject of their knowing, again, was different.

Transformative mechanisms, as with the articulations, were present at both levels of discourse although the objects of hoped transformation are distinct – for the WHO texts, it is national mental health programs and care that are to be modified whereas the Chilean texts aim to change both the way mental health professionals provide care and the individuals experiencing depression. Not only do the transformative mechanisms in the national texts aim to help the individuals to no longer be depressed, they aim for the individuals to have new understandings of what depression is, how it should be treated, and the active role of the individual in the process.

Aside from fitting with biopolitics, moving from the global to the national level of knowledge, evaluation tools, and treatments for depression shows a shift from general biopolitical goals to biopolitical goals achieved through biomedicalized means. Biomedicalization represents the idea that through more human conditions are coming under the medical gaze, managed through advances in technoscience such as pharmaceutical interventions

that act upon chemical compounds within a person's body²³. In the national texts individuals are not only urged to listen to their doctors and to follow medical advice in sticking with treatments, but they are also compelled to consider themselves as ultimately responsible for their wellness by taking an active role in the treatment process to shift from reliance on doctors as agents implementing change to self-reliance, drawing from doctors for information and education. This focus on self-regulation facilitates individuals' understandings of how management of their own ailments contributes to what is understood to be the larger good. Because this occurs through the health care system and use of various therapies, depression and mental health in these texts further the fit of biopolitics as a guiding framework and may be also understood as what some have termed medical neoliberalism (Fisher 2007).

Conclusion

This chapter has explored representations of global and national psychiatric knowledge using biopolitics as the guiding analytic framework. While biopolitics is a useful frame to evaluate depression and mental health at both national and global levels, Foucault's definitions of biopolitics fail to capture all of the nuances of the construction of the two concepts. An important piece at both the national and global levels which is left out of Foucault's biopolitics is the notion of risk, which could be defined through the collected texts as a person's likelihood of or vulnerability to developing mental illnesses or depression, with factors that can increase or decrease that probability. Risk can be biological, economic, or "psychosocial." Factors seen as increasing risk are life events or conditions that happen to individuals, such as stress, death of a

²³ The key difference between medicalization and biomedicalization is the latter's focus on technoscience; while medicalization generally explains how certain illnesses, disorders, or conditions have come to be seen as medical problems, biomedicalization explores this topic through the management of such conditions using technologies that act upon individual bodies, typically in ways the human eye cannot capture on its own.

loved one, or having a relative with a mental illness or depression, whereas individuals' actions against such factors provide the means for decreasing risk.

A second area that has been left out of Foucault's original biopolitics is the idea of the "social," which through analysis is important to the construction of depression at the national level. Here, social refers to the possible causes of and treatments for depression that relate the person experiencing depression to other people in the environment. For example, the clinical treatment guide for depression explains that many of those who develop depression have experienced a traumatic event in childhood such as the loss of a loved one, or are victims of domestic violence (12). *Vencer la Depresión* (7) explains that many times people become depressed due to stress, and also elaborates gendered differences in depression and suicide attempts. "Depression is overvalued in our [Chilean] culture" (7, pg. 87), a theme which will be revisited in subsequent chapters.

Generally, biopolitical goals are reflected well throughout the MIND Project, in constructions of knowledge about depression and mental illness, in articulations of knowledge which operationalize that knowledge, and through the transformative mechanisms which seek to enact change based on such knowledge. Many aspects are adequately captured by biopolitics, although the notion of "risk" is not adequately considered in Foucault's original theory. Chapter 7 will discuss this and additional elements to modify the theory of biopolitics.

CHAPTER 5: THE MICROPOLITICS AND EXPERIENCE OF DEPRESSION

On the first Friday in July, Gloria was referred to the in-patient clinic at Hospital del Salvador directly from an appointment at her neighborhood's consultorio in Las Condes. She stood approximately five feet, ten inches tall in knee-high black boots with black tights, and a purple and blue slinky dress that stopped short of her knees. Her wavy, black hair was cut short with wisps falling down the back of her neck. Although Gloria had accomplished a post-secondary technical degree, she was not working at the time she entered the in-patient facility. That day, she spoke openly and almost conversationally about the recent events in her life. Her father had been very sick, and died in her arms only five months before. She had been wanting to commit suicide, with a plan to throw herself in front of a subway train while holding her son in her arms. She explained to the head nurse and occupational therapist that she had previously been diagnosed and hospitalized, and pharmaceutical interventions did not work for her. "Drugs are almost useless," she said, before saying that she wanted electroshock therapy. The intake interview then ended abruptly, and after the occupational therapist escorted Gloria out of the room, the head nurse asked me what I thought about the new arrival. "It is interesting that she wants TEC [terapia electroconvulsiva, electroconvulsive/electroshock therapy]," I said. The head nurse responded that it was common that patients ask for TEC because of the "show" of it, going to a different area of the hospital for the TEC sessions, having to sign forms, and being informed about a unique, exotic treatment. For some patients, she said, the spectacle alone worked great. "So it's more a placebo effect?" I asked. "Yes, the placebo effect works wonders," she responded.

Gloria's connection between negative emotional states and desire for suicide with a globally recognized, official psychiatric diagnostic label and knowledge of acceptable treatment options within psychiatric standards and health care service capabilities demonstrated the co-constitution of new forms of knowledge, technoscientific interventions, and services characteristic of biomedicalization (Clarke et al. 2010). Gloria's insistence on the necessity of biomedical intervention for her survival along with her knowledge of particular kinds of interventions as ineffective for her represents a level of transformation of her own identity and subjectivity as part of the processes of biomedicalization of depression in the context (Clarke et al. 2010). The head nurse's dismissal of Gloria's request for *TEC* treatments asserted a classic power differential between patient and provider, and in biopolitical terms indicated that from the expert perspective it was really the provider, rather than the patient, who knew best what intervention to utilize. This chapter delves into the personal beliefs and experiences immediately surrounding depression, including defining the disorder, thoughts on causes and essential treatments, the role of care providers as experts, and ideas of moving forward from depression, juxtaposed with theories of biopolitics, biomedicalization, and mental health to provide an analytic of the micropolitics of depression.

In the following Monday's rounds of interviews the entire staff arranged to speak with Gloria. After the weekend in the hospital, she looked tired as she shuffled slowly into the staff room with her eyes slightly closed. Gloria sat down and the interview commenced, with four medical students and the head psychiatrist listening attentively. Gloria described herself as overly demanding and perfectionistic. While she was employed, she would often work from 8:00 am to 11:00 pm instead of 6:00 pm out of sheer desire for her work. Gloria first experienced depression six years earlier, at age 30, when her brother had an accident and was in a coma for

twenty days. The same year she gave birth to her son. During her pregnancy, she had problems with her partner and although she broke up with him, he continued to bother her. Gloria's father, she said, died recently of a lung infection and had advanced Parkinson's disease. His passing greatly affected Gloria, even though during her childhood he drank alcohol often, causing her to lose trust in him as a provider, meaning she had to mature early. She came to the hospital the past Friday because she found herself unable to cry and felt she had a depression she could not get rid of. "It's like everything bores me,"²⁴ she said, although she felt a lot of things around her had a negative effect on her. Gloria had tried twice previously to kill herself by taking seventy pills and cutting her arms. This time, she wanted to throw herself in front of the subway train with her son, because she couldn't bear the thought of her son being on his own after her suicide. It would be better, she reasoned, if he died then too. Killing herself, she told the doctors, would solve her problems without bothering anyone. Gloria said she didn't want to be hospitalized a long time, she just wanted TEC and to go home to her son, who she missed terribly. "I want to stabilize myself quickly, to be with him." Over the course of the weekend she was prescribed and began taking five pharmaceuticals, including risperidone, clonazepam, and paroxetine. She reported that her body was shaking a lot, and she was not sure why. "I needed to hospitalize myself but I didn't want to just take pills," Gloria said. "I want to put my emotions in order and I want to be able to withstand more."

For Gloria, engaging in biomedical, technoscientific interventions such as pharmaceuticals or electroconvulsive therapy was not about changing the conditions of her life that lead her to feel depressed, but for her to be able to continue in her life without it having the

²⁴ This phrase in Spanish does not neatly translate to English. Gloria's statement, "*es como que todo me aburro*," could also be interpreted as Gloria saying that she finds herself disinterested or apathetic about everything.

same effect on her. In other words, Gloria was seeking to optimize or enhance her ability to tolerate undesirable circumstances, for her to be made to “live better” through technoscience (Clarke et al. 2010). Often pharmaceutical interventions are utilized in the maintenance rather than changing of a lifestyle (Dumit 2012), but in Gloria’s case it was more about desensitizing herself to the conditions around her than it was about keeping her physical body functioning in a socially desirable way, such as in the case of male sexual performance and other drugs that work to keep male bodies functioning as if in perpetual youth (Conrad 2007, Clarke et al. 2010).

A few days later, in an interview for this project, Gloria told me, “I am a person who in reality, I’m pretty happy. I have like two phases. I’m more in the depression phase but I have, em, I am a person who in reality I like to do well, be well with others.” She told me her six-year-old son was “a very loving boy, he’s the one permanent thing in my life.” Gloria felt the death of her father ignited her recent “crisis,” as she described it, which meant for her to feel hopeless and “to begin to feel anxiety, really scary, crying and crying. [With] this amount of anxiety I wanted to disappear from this world, I wanted to disappear and I thought I was doing the right thing thinking about my son and after my son – I was being selfish because it was my problem, not his.” Shortly before her referral to the hospital, Gloria had gone to a subway station with her son and said at that moment that “the angels that come out of the light, they told me not to throw myself in front of the train. And it was something like, not that I didn’t want to throw myself... it was like something, I don’t know, like divine. I think it was divine. Because I had faith in him [god]. A lot of faith. That for me was like a switch.”

“Depression is a, for me, is a state in which one enters, in which one needs tranquility, needs therapy, needs value, a lot of value as a person, because that causes anxiety and much shame. That is super important. It’s when one reaches the bottom, when one reaches the

bottom, and has, have a very large anxiety in the sole [from which] one cannot *salir adelante* alone. You have to do it with someone else. To help yourself... They say the causes are genetic.” “What would you tell someone who has depression?” I asked her. “That it’s an illness, so negative, so negative, but that you have to ask for help. Ask for help. Ask for help because many people who develop depression don’t ask for help. That they see to solving their problems because that will happen with time. Get treatment whether in short or long term but so they can get a solution to their problems. [Help means] with doctors, or psychiatrist, or psychologist, that are really important, like psychotherapy, and that you take *fármacos* [medication/drugs].”

Gloria had begun electroconvulsive therapy since her interview Monday with the staff. “How do you feel about that?” I asked. “A bit frightened because one does not know what is happening [during *TEC* sessions], but [one] trusts, that it can result like no, like no other things have done.” Gloria had tried many medications in the past, “and they didn’t do anything for me, apart from – what did they do? Oh, the side effects, that I was allergic to them.” A medication she was taking at the time of the interview caused her hands shake, she told me, which made everyday tasks, such as bathing, very challenging. Gloria felt she was able to connect with other women in the in-patient facility, that they told her “that I have to *salir adelante*, that I have to get better, that I have to be patient.” “The doctors know what they’re doing so you have to listen to them. I have faith also because of my son. I have to get better for my son.” Gloria explained that because of *AUGE*, she did not have to pay for the services at the hospital. “And I hope this works because it’s like my last, my last option.”

Like all of the other patients I spoke with, Gloria did not have to pay for the health care services she received because of the *AUGE* program providing treatments for depression. This guarantee of care was made available to all those who were citizens of the country; the notion

that belonging to a particular nation-state should grant an individual the ability to access medical care in that country has been referred to as medical citizenship²⁵ (Wailoo, Livingston, and Guarnaccia 2006). As Vicente, an outsider, explained, “I can get depressed, but calmly because, because the illness is financed.”

Gloria’s account points to several thematic elements that swept across other patients’ descriptions of their experience as well as their explanations for depression, including seeming conflicts between perceived cause of and suggested interventions for depression, reliance upon medical doctors, psychiatrists, and psychologists as mental health experts, and the hopes and fears of *salir adelante* – moving forward in life. This chapter will elaborate not only patient understandings but also those of outsiders and care providers handling depression. The chapter will explore how biology and social factors are interwoven to create narratives of depression that at times are contradictory, as well as the role of care providers in the treatment of depression.

Individual Constructions of Depression: Symptoms, Origins, and Remedies

Patients

“Depression is, it’s without energy, without anything, crying all the time, eh, without, without want [to do anything], everything is bothersome, up until I want to keep myself enclosed and, and no one bothers me,” explained Francisca, a patient.

Like Francisca, most patients who experienced depression often felt that depression meant feeling a lack of desire to be around most people, and to engage in activities, wanting to keep themselves closed in their rooms with the primary goal of staying away from people and

²⁵ Medical citizenship has been used only to signify rights to access to services (Wailoo, Livingston, and Guarnaccia 2006), whereas biological citizenship differentially emphasizes how individuals understand their health and medical needs, and not only that they have a right to existing services but that the government should create new provisions in the face of new health problems and demands.

social activities. Everyday tasks felt excruciatingly onerous, and many said they preferred to stay in bed when feeling depressed. Gloria stated above that depression meant one needs affirmation of their own value or worth, and that one would experience anxiety around this. Other patients similarly expressed that part of the desire to remain socially isolated was from fear of being different than, or of being judged by, other people.

Isabel described depression: “I don’t matter. No one loves me, no one can. I look in the mirror and I see nothing. No one is interested in me. I live because it is necessary to live. I feel a lot of sorrow. It takes a lot to get out of bed.” Isidora also explained, “Ahh, it’s that I want to kill myself, and I don’t sleep, I’m very anxious, um, and very different with everyone else.”

Patients experiencing depression noted they felt such feelings were a distinct break from the past and normal emotional expression. “I, before, was always really happy... then my husband asked me what it was that I had and I said that I didn’t know, that I felt weird, I felt bad, that I didn’t want to live, I didn’t want to eat. And there he told me, he brought me to the doctor and the doctor told me that I had depression,” Catalina said of her experience.

A few patients described how depression changed their personalities, that with depression they are different people. “I was like really happy, like problems didn’t matter to me. There wasn’t a thing that I couldn’t figure out. Now I don’t feel the same way, like I’m turned off, not wanting to do anything” (Angela).

Monica noted that she generally felt she was an unsure person, but at the time of the interview she no longer felt healthy. “Right now, I’m insecure about everything. About everything. A year ago I felt well. But insecure.”

In describing herself, María said “[i]n this moment... a person with low self-esteem, completely low, to a really low point, ehh, with anxiety, a person who is very vulnerable to

whatever person or thing that happens to me, it lowers [my self-esteem], it hurts me, it damages me. In other words, it breaks me,” she said. María interpreted the question as being about the present moment, as distinct from an earlier time. She felt that everything she encountered was hurtful to her.

Through the course of Teresa’s initial assessment at the in-patient facility, even though Teresa gave many examples of stressful interpersonal conflicts, she commented that she felt out of control of her mind and thoughts:

On the morning of the last Wednesday in June, I was sitting in the staff room of the in-patient ward in the hospital. Teresa was a newcomer, having been admitted through the emergency room the night before for being wildly out of control, fighting with her husband, and throwing things. Teresa looked younger than her 47 years, with dirty blonde hair that curled as it reached past her shoulders. It was a cold day, so she sat wearing both a brown mock neck sweater and a coat. She sat in a chair against the wall while the head psychiatrist interviewed her. “I feel useless. It pains me, it makes me mad,” she said. “I feel very guilty, very useless. I’m good for nothing.” Teresa had her hands in her coat pockets as she spoke, making eye contact with the doctor. “I’m scared to go back home,” she said, as she explained that she was worried that she would be abused by her spouse, who uses a handful of illegal drugs and alcohol. He’s been fairly controlling of her, obsessing over her schedule and calculating where she should be. “He tells me I’m unfit, I’m not able to work,” Teresa said, describing him as a chauvinist. Sharing background about her life, Teresa mentioned that she first experienced depression around the age of 14 or 15. “All of my life, I’ve had a very big sorrow.” “What do you hope for with this hospitalization?” the psychiatrist asked her. “To settle myself,” Teresa said. With her right index finger she pointed to her temple, saying, “There’s something here that

doesn't work well. What is it I have? Why do I think what I think? Why am I not like other people I see who smile, but have some problems and don't want to kill themselves, but have hope? ... As I am, I don't have a life. It's horrible not to feel that one wakes up [from this]. It's not that it's another day, it's torture."

Teresa described her life and her experiences of depression as intertwined, although she did not point to the social conditions of her life as the cause of her sorrows. In spite of the social conditions of her life that may have contributed to her feeling hopeless and sad, such as her abusive and controlling partner, Teresa in pointing to her head pinpointed depression as originating somewhere in her head. She reported that she experienced depression for decades, interpreting those feelings as the result of something malfunctioning inside her head, something which she could not understand and could not control.

Much like Teresa's experience, Constanza felt out of control of her thoughts and her perspective towards life. "I don't want to do anything," said Constanza, who described herself as depressive. "And, and, moreover, with suicide attempts. Because it's like the mind puts everything in black, in black, black, black, and you can't do anything, only see that it won't happen anymore." Depression had the effect of giving Constanza an uncontrollable and extremely pessimistic outlook, to the point where she felt she had become lost and her only feasible option to no longer have those negative feelings was to no longer exist.

Several patients described depression as a foreign entity, where the mind removed control from the individual in an inexplicable way. Estefania explained, "[d]epression to me is a state of mind in which one can't control certain emotions." She continued:

"My experience with depression has been ugly... no, I don't like it, no, because one knows that one can, but your mind doesn't tell you- it's like, like how could it be that something takes over what you have pro-, programmed in your life? How could it be that

you can't control your mind? Because many people tell you, 'Yes, you can do this, you can *salir adelante* yourself' and it's not like that or I would have done it already."

Estefania felt depression had taken over and disabled her own autonomous thinking, thus derailing her life. When one is not in command of his or her own mind, Estefania would reason, daily tasks and routines fall apart. Because Estefania understood depression as removing control over her mind and life, she felt depression also meant one could not overcome it through sheer will or individual effort, unlike the popular sentiment she had encountered.

María said, "...My depression is physical. Very destructive." To María, that depression had played a negative role in her life, where she had not intended for things to deteriorate as they had, meant that depression was physical, biological, and beyond her control. Because of depression's perceived autonomy, it was able to cause harm to María's life in a way she was unable to manage.

One patient believed her depression was inherited through the family, and as such, affected everything about her. "My depression is hereditary. It influences my way of being," Carla said. Carla felt that her biologically inherited link to depression meant that depression shaped her personality, her actions, her beliefs, and manner of navigating life. Seeing depression as affecting one's way of being made it more difficult for Carla to imagine new realities for herself without depression.

None of the patients interviewed explained depression as constructed through the ICD-10 or DSM, although several elements are similar: feeling a loss of interest in activities and people, sadness, and changes in energy levels such as wanting to sleep more. Biologically-colored languages were largely absent from patients' understandings of depression, aside from Carla's statement about her depression being hereditary. Rather than explaining depression as a biological problem within their bodies, patients turned to tropes of illness.

“It’s understood that depression is a state of illness,” Estefania told me, thankful that society viewed depression in this way. The idea that depression was an illness meant that it was seen socially through more of a medical model than many mental illnesses had been historically, where it was understood something was wrong with the body which required one to seek attention from a licensed care provider or doctor; people with mental illnesses are patients who should follow the orders of their doctors and through those treatments, people would recover. Participants who had been diagnosed with depression felt that depression was being seen more and more like an illness, comparable to any other physical illness, such as diabetes. “For all of us it’s an illness, and just a bad illness” (Claudia, patient).

That depression was socially seen as more of an illness than madness or laziness had repercussions for those who experience depression. Interviewees diagnosed with depression felt that the popular narrative of depression as illness was helpful in reducing stigma and in making treatments more widely available. Whereas historically depression was seen as insanity, being a freak, or laziness, and thus something from which most would distance themselves, depression as an illness made the experience more understandable to those who did not have it, with the population having the impression that depression was caused by a biological problem in the body, not a moral failing of the individual. Women with depression in Japan similarly struggled to find others who would recognize their experiences as legitimate mental distress rather than laziness (Kitanaka 2011).

“I think that it’s a big help, that depression would be like an illness, that it’s not a state of madness or schizophrenia for people... That they see it as a normal illness, but rather as if they saw it as a freak, it would be, I think, much more that people would fall into depressions from which they would not be able to recover... In the current time, thanks to God, it’s seen as an

illness and not as madness” (Estefania, patient). Interestingly, Estefania contrasts depression as an illness to madness, being a freak, and schizophrenia, where those terms connoted a distancing of general society from people with depression, a lack of understanding, and a lack of willingness to help those suffering. That depression is seen as an illness means that there is an acceptable method of treatment available that is accessible and respectable. Estefania felt that the more heavily stigmatized depression was, the more difficult it would be for people to return to their previous well-being.

As Martina, also a patient, explained, “[a] large percentage of the population hasn’t realized that this is an illness, it’s an actual problem.” Martina felt that stigma in society was still very present, but if people would realize that depression was an illness they would take it more seriously. Representing depression as illness does the work of making depression a more common, familiar, comfortable concept while still communicating its severity; if illnesses go untreated, they will get worse and perhaps end in death. The same is conveyed for depression when constructed as an illness. That illnesses are understood as outside of the control of their sufferers also points to biological determinants of symptoms; to describe depression as illness is to indirectly rely on biological explanations for the disorder, although not in terms conforming to the languages of the atomization of illness as in processes of biomedicalization (Clarke et al 2010).

Gloria was one of the few patients who described depression as genetic in origin, although with regards to her own feelings, she thought depression was brought on by the stressful passing of her father and other social factors. Many patients thought of depression as being caused by overwhelming problems faced in one’s life, generally expressing that people face an accumulation of issues or events in their lives that can overwhelm them, leading people to

feel depressed. Carmen (patient) sums this up nicely: “[What causes depression are] the problems that one really has accumulating a lot, until one breaks.”

When asked more specifically about what problems may be those that cause depression, patients pointed out several unique social issues: stress at work, a missing parent, economic difficulties, or roles within the family. “Could be many causes,” explained María, “Could be of a need, of an absent parent, or for feeling another way, for a perfect example, problems of class can also produce depression. Abuse too, sexual abuse.”

Kleinman’s work on neurasthenia and mental illness more broadly similarly showed that people constructed their mental illness experiences as due to interpersonal problems, communication issues, or dilemmas at work (Kleinman 1982, Kleinman 1988, Lee 2011). While neurasthenia is often described as a more somatic or physically based illness than depression, within the Chinese context such expressions were more socially acceptable. Distress that individuals face due to problems in their lives can trigger biological reactions although social scientists are likely to point to how such labels of psychiatric disorder are signs of social pathology (Kleinman 1988, Szasz 1961). In the Chilean context at the time of fieldwork, restrictions about expression of difficulties related to emotions and social contexts were not present, although many patients felt they could not or should not discuss their depression experience with others for fear of an absence of understanding, or worse, the presence of judgment. Such evaluations of states of ill-health representing poor morality or values pervade health in general (Metzl 2010).

One specific problem that many patients listed as a cause of their depression was the death of a loved one. Nearly half of the people diagnosed with depression who were

interviewed, like Gloria, described having faced the loss of a loved one in their own narratives of depression.

Coping with the loss of her father who served as an important support to her, Estefania felt like other issues arising in her life pushed her over the edge, making her feel out of control and depressed. “The problems were coming starting a year ago, more than a year ago. My father died two and a half years ago, and, after that my son began to repeat three years in a row [in school] and like, I didn’t know how, how to act... it was like the straw that broke the camel’s back.” In trying to cope with her father’s passing, Estefania felt fragile and that the additional emotional weight of her son’s lack of progress in school was too much to bear.

Constanza, also a patient, described to me the situation with her adult son. The whole family had noticed him acting strangely for months; the family, Constanza included, attributed his chronic laying on the couch to sheer laziness. This attribution gave her an intense guilt after finding out the gravity of her son’s situation. That his diagnosis and passing came so quickly together – within one week – and that she was unable to help him after the accusations of laziness made Constanza feel intensely distraught. “[I came to the hospital] because I hadn’t been able to bear it, of my son, the death of my son... Last year around Christmas he went to the hospital and they told him it was cancer, they gave him medication and he died after the New Year. So yeah. That’s everything that happened... [I feel] terrible. I wanted to die. I feel useless.”

Florencia, like Estefania and Constanza, also felt overwhelmed by the loss of a loved one. Florencia’s grief was compounded by the accumulation of sadness and stress from having lost her daughter and her husband within a four-year period. “I tried to kill myself three times. After four years had passed, my husband got sick... and passed away... So that complicated my life

because I have a lot of sorrow.” Florencia’s husband served as a constancy in life, and as a protector. Due to his death, she felt scared, abandoned, and deeply saddened. “Mine [depression], I think it’s because of my sorrow, and because I feel very alone, I feel unprotected. Because I lived 37 years married, with the same spouse, always the same spouse, so, one goes and feels unprotected. He abandoned me, [left me] alone.”

Francisca similarly had a difficult time due to the manner of several relatives’ passing. “Well, it began because before that it began that I, I think it came for the death of, of my sister, the death of my husband, and the death of his brother. They all committed suicide.” Francisca attributes her depression to attempting to cope with the losses themselves in addition to trying to understand why each of her loved ones felt the need to pass as they did.

The explanations patients described as the origins of their feelings of depression were not overtly biological. Patients elaborated on interpersonal problems with family members or coworkers as precipitating their feelings of sadness, rather than looking to biochemical reasons. Deaths within the family were also attributed as the cause of upset and depression by patients, rather than biological factors such as malfunctioning neurotransmitters.

Like Gloria’s suggestion that people with depression see doctors and make use of pharmaceutical interventions, the overwhelming response from other patients about what someone with depression should do was to “get treated,” often through utilizing drug therapies. Although this contradicts how most of the patients interpreted the causes of their own depression, it is not entirely surprising as pharmaceutical interventions have become normalized not only within psychiatric practice but also in everyday life (Orr 2010).

“That they look for help... Each person knows how they can help themselves” (Estefania, patient). Carmen (patient) explained “[w]ell, that they have to get treated... with the

general physician.” Carmen would advise someone to advance through the different levels of health care by beginning first in primary care.

One patient elaborates by saying that the health care services are useful and that it has become so easy to receive the services that accessibility should not be an issue. “What I would say first, that they get treated.... That the *policlínico* of [Hospital de] Salvador is really good... It’s not difficult to enroll. You have to do it” (María, patient). There was no question to María that medical interventions at the hospital are necessary to overcome depression.

Estefania felt that she was often told she could overcome depression on her own, to be healthy and continue in life, but that others would explain that she should get professional help. “Many people tell you, eh, ‘you can leave, you are capable of leaving,’ but there are other people who say help. Look for help, look for professional help, or something, someone who understands you.” In this case, professional help means that one is finding assistance from another individual who is trained and licensed to comprehend the problems at hand and how to deal with them. At the same time, this statement may still express a sense of being stigmatized for experiencing depression as one could infer that *only* a mental health professional was able to understanding depression, and others were not.

Outsiders

Outsiders felt depression meant feelings of sorrow and profound solitude, as Jorge described. “Depression is like, loneliness, sadness, more absolute than one individual can feel.” “For me,” said Gabriela, a university student, “depression is a state of profound sadness and of not finding, not finding like, like to do something, how to fulfill something. That is what I think. Well, my mom had depression for a long time, and I feel that it’s what she constantly like, looked for, as if nothing, there was nothing that could fill the cup that she has.” Gabriela

understood depression to be more than not wanting to do something, but that even when doing things that they did not seem to be as rewarding as one may have expected them to be, leaving a sense of disappointment. For many outsiders, depression meant a lack of desire to complete everyday tasks and obligations.

One teacher thought depression meant having no ambition to do things and having difficulty in social situations, as well as having a negative outlook. “Depression to me means to be without a desire to do anything, you don’t want to do anything, and it probably takes incredible effort to be with people, I think. To have a sensation of sadness, of sorrow. To me, depression I think is when *everything* seems negative to you, everything seems bad to you. Eh, nothing, *nothing* can be nice in the day, and no, it doesn’t matter. Nothing works” (Luz).

Vicente (outsider) explained that he thought depression was caused by disease or physical disturbance: “Depression, I believe it’s a pathological illness, of course.” However, as noted above patients did not feel all people saw depression as an illness, which meant that non-believers would downplay or at the very least not recognize the severity of depression for those who experience it.

Some outsiders recognized that depression was seen as more of an illness contemporarily than it had been historically. “I think that now it’s seen more as an illness than before. I mean, I think that before they didn’t realize, because no, no, no, I don’t know, for example now the psychiatrists say depression and the people are like ‘ahh, that person has depression,’ but before it was like due to laziness that they don’t go to work, or something, because of laziness they don’t do this. That’s how I would say for now it’s taken more, more as an illness, and it’s taken as prisoner by doctors” (Cristina, outsider). Historically, depression would have been interpreted as an unwillingness to work or handle one’s responsibilities, but taken as an illness,

the inability to manage one's duties is interpreted to mean the individual is no longer in control of his or her life because of a physical, internal, biological problem. Cristina felt that the term "depression" was understood by the population without the necessity of explanation. The statement that Cristina makes about depression being a "prisoner" to doctors indicates that the medical model may now be the only acceptable manner for handling depression, and that doctors have staked claims over expertise on depression; she implies that this may not be an entirely positive phenomenon.

Outsiders generally had a difficult time elaborating on what depression was, choosing rather to respond to the question in terms of its causes. Explanations of the causes of depression by those who were outside of the medical realm were a mixture of biological and social in origin, although they more often were biological.

Vicente (outsider) said, "There are depressions that are chemical depressions, there are inherited ones, genetically inherited, chemical, and, and they have to work with psychiatrists, with psychologists..." What Vicente points out is that aside from depression being based in genetics or chemicals, there is a requirement that people with those types of depression must have the aid of an expert to overcome the condition.

"[Depression] is like a sorrow, but, more than sorrow. It's like a sorrow that's from your brain," described Tomas, a student. Tomas pinpointed the brain as the location in the body from which negative emotions and sadness stem, as the biological source of depression.

More than simply biological, Mariana (outsider), like Vicente, explained that depression could be genetic. "I feel that there could be people who have like, have something like almost genetic about it, like I feel that it could be that they are like almost forever a state more or less very depressed." The distinction Mariana makes that depression is genetic is significant in that

this term implies that depression is an unchanging hereditary predisposition rather than only referring to depression as being, for example, the physical circulation of chemicals within the brain. This outsider felt that depression as a genetic entity meant that one would never truly be cured or fully recover from the condition, but rather that the person would always be depressed as it was seen as part of a person's hard-wiring.

Aside from referring to depression in terms such as biological, genetic, hereditary, or inherited, outsiders in particular spoke of endogenous depression. Endogenous depression, literally meaning "from within," represents the idea that where there seem to be no other possible causes, depression is assumed to be biologically based. This is contrasted with exogenous depression where the causes are understood to be stressful life events²⁶. For example, one outsider explained, "[e]ndogenous and exogenous depressions exist, but I don't have very clear which ones are- the differences. I know that one has a genetic presentation, and the other doesn't" (Jorge, outsider). Interestingly, he describes endogenous depression as having something to do with genetics and exogenous depression he describes only in opposition, of not being genetically determined rather than directly explaining another possible cause.

Veronica, a university student thought depression could be caused by family problems. However, this student took that one step further in explaining that such stress that had people keep bottled up is what causes depression.

"For me, it's like problems from childhood or in life that aren't resolved and that actually in some moment in life trigger it, yes, for example, some type of shame that a person has because of some kind of violation of rights, maybe physical, like psychological that a person lived through at one time, and that they didn't verbalize and afterwards would be in a profound sadness. For me that is depression, like having a lot, having hidden secrets, and after the event being in a mood of sadness. And sadness that's very profound" (Veronica, outsider).

²⁶ The terms endogenous and exogenous are largely passé in contemporary western psychology and psychiatry (Kramer 2002).

For outsiders it was not quite as easy to describe potential causes of depression, although some of the outsiders who had known someone with depression identified a few socially-oriented reasons quite similar to those who experienced depression first-hand. “And when an individual feels loneliness, for, let’s see, lost loved ones, for some very traumatic situation, for a hard life” (Jorge, outsider). What could be a cause of depression? “All kinds of problems. Economic problems, money problems, eh, social problems, work” (Camila, outsider). Overall, the outsiders’ explanations of the potential social causes of depression stayed on a much more general level than the detailed explanations given by those diagnosed with depression and care providers.²⁷

Emilia felt that in Chile it was difficult to be financially wealthy, which caused stress not only for an individual but for the entire family. This stress could lead people to be depressed, in Emilia’s view.

“Maybe, in Chile, for me it could be the fact that with, with work and always with studies, you can’t be economically well-off, and that causes a lot of family problems, and it could be that there is more than one motive for depression because people feel dissatisfied, with their housing, and fighting with their family, and the family with the kids, and the kids can’t develop because they don’t have the, the economic power to be able to do so. That I think could be one cause [of depression]” (Emilia, outsider).

Luz, a teacher, felt that the lifestyle within Santiago was very stressful, from the commute to work, to noise pollution, to a lack of money could make someone feel depressed.

“Probably, let’s see, in Santiago. I think, maybe half of Santiaguinos I think [have depression]. And it’s from the way of living, too. Because Santiago is a country [sic] where first the people, it’s that, they have to travel around two hours to get to work. Imagine it. Eh, traveling already produces stress for you, and then to return home... The pressure in work, probably family problems, lack of money, and now the economic crisis happening, people without work, this, this theme and other themes, eh, I feel that the people here in Santiago are a little bit depressed, that they need to smile more... I think it could be due to place because normally the big cities, in the big capitals like Santiago, Buenos Aires, there are so many people, there is noise pollution, with the cars, so I think

²⁷ This could be merely due to a lack of personal experience with depression.

that produces uh.. Air pollution too, millions of people, everyone wanting to return to their house, to be calm... In Santiago, yes, I know that there are quite a lot of depressed people” (Luz, outsider).

In general, one outsider explained, the broader social attitude was that pharmaceutical intervention was the manner with which people would handle depression. “I think Chileans, how they see it [depression], is like something that you can treat with medicine” (Jorge, outsider). From the perspective that society interprets depression as an illness, understanding that other illnesses are handled with medications, it makes sense that people would feel depression was treatable with medicines.

One outsider said that she would consider help to be social networks first, although they may be limited in what they are able to accomplish. “...Like social networks one could say, like my family, my friends, and also I consider help for example, if I feel that the[ir] best isn’t sufficient, professional help. Like a psychologist, I don’t know, a psychiatrist, some therapy” (Mariana, outsider). When social networks are ineffective, according to Mariana, one should seek help from mental health experts who have more knowledge in how to handle depression. To Mariana, however, the solution to depression is to talk about one’s problems and feelings with others, rather than engage with pharmaceutical interventions.

Similarly, Emilia expressed that it would be necessary for someone to take a number of steps in overcoming depression. “To accept that one needs help, I think, is very important... [I’d tell someone] that they leave space... to be able to go to the doctor or to therapy” (Emilia, outsider). Emilia felt that to treat depression, the individual must first realize that they are in need of help, and further, they must allow themselves to receive the assistance of mental health care professionals.

Additionally, Juliana felt that professional health care providers had a unique ability to assist individuals in removing the depression inside of them: “What would I say. Hmm. I don’t know, go to get treated, go to some doctor, a psychologist, reach down and try to take out what you have inside, try to get better... Get a professional who can help you not to continue in that same state. To overcome it.” To Juliana, experts would be able to help individuals to rid their bodies of depression so those individuals could continue in their lives, as healthy people.

Veronica, an outsider, distinguishes somewhat between the needs for someone suffering from mild or severe depression. “Go to a psychologist or whatever may be really a very, very mild depression. For a severe depression maybe go to the psychiatrist, and there are studies to see really if your brain is lacking some type of vitamin... see a psychiatrist and a psychologist to combine a, some type of therapy.” Drawing from biological notions that depression may be about lacking a vitamin in the brain, Veronica believed it might be important to understand what was causing a severe depression. Veronica saw therapies from psychiatrists and psychologists as the best solution.

Cristina (outsider) notes that although she feels people with depression should take medications, they do not always do so, out of fear that the side effects may be worse than the symptoms of depression. “[I would say to someone with depression] that they get treated. (laughs) No, but in reality that, I mean, because people with depression sometimes don’t take the medications, that it’s all treatment, and I don’t know why, because they think with the side effects that it has.” Cristina went on to tell about the situation with a friend of hers, who stopped taking antidepressants because her friend worried that the side effects of the medication would more severely impact her health in a negative way, such as through creating heart and lung problems.

Vicente had a more urgent feel to his sentiment that people with depression should see health professionals who use science to facilitate the healing process. “Well, I would tell them first that, that turn off the car, stop the car, right? And that, and that they put their problems in the hands of science, in the hands of people who effectively can support them and help without shame... The professionals are there so they can help leave more quickly, leave better, and leave without wounds.” To Vicente, people with depression needed to suspend their lives temporarily to ask for help from experts. Vicente’s statement implies that mental health professionals, by relying on science to support the care they provide, avoid placing stigma and blame on patients. People will be able to be healthier and be less harmed by relying on mental health experts than attempting recovery by other means.

Luz, an outsider, explained how an acquaintance felt depressed, and required medicine because depression was something biologically caused that would endure over the life course:

“A friend of my mom, for example, she suffered from endogenous depression. And I wanted to know why because I was a person so positive, like that I am always happy, but it’s, it’s my way of being, that it’s that way, but the truth is sometimes it’s hard for me to understand how a person having all the things to make someone happy, isn’t [happy]. So the woman had a marvelous husband, they lived, well, they didn’t, didn’t happen upon economic poverty, and she sometimes had crises, in which she couldn’t leave the house, was in bed, and couldn’t get up. I would ask her, um, why, it’s a person who goes, like, between the extremes. When she arrives to the house she’s *very* happy, I always see her happy, cheerful, always arrived happy. I couldn’t imagine, I couldn’t understand that this person would have that, that, that type of endogenous depression. So, she commented to me, ‘Look, to feel this is like a sorrow that follows you forever. It’s a sadness that always follows you. And one must take medicine for it.’”

Luz had difficulty understanding why a person who seemed to have many positive aspects to life – a family, a place to live – would have depression, implying that one should not feel sad if those needs have been met. In such cases, social comparison with others, Luz felt, should not allow for someone to become depressed. The only logical explanation to Luz was

that something was physically wrong within the person's body that would lead to feeling depressed. Defined as a physical problem, taking medication for depression was rational to Luz.

Another outsider told me a similar story about someone she knew: that depression as a hereditary, physical problem required pharmaceutical treatments. "She has it, for example, a genetic inheritance because her mother also died from depression. So in a certain way she has this genetic tendency, went through like, very difficult things in her life up until the moment arrived when things changed... with visits to many doctors, psychiatrists, psychologists, and up through today, I think that she still has endogenous depression. She needs to take a pill every day to feel well" (Veronica, outsider). That Veronica's friend continues to take anti-depressant medication even after consulting with care providers is a signal to Veronica that something is amiss within her friend's body that requires pharmaceutical treatment.

Providers

Care providers similarly felt an additional component of depression was not just the lowering of mood but an actively negative or pessimistic outlook. A psychologist at one of the hospitals explained, "[t]he depressed patient doesn't have any idea of the future, the present is dreadful, and everything that happened was better" (Carolina).

A social worker in the day hospital explained that those with depression have a completely altered perspective that affects how they see themselves and others.

"I saw an article on this that was very interesting, that said people who have severe depression see colors differently. The colors they see are more grayed, everything is gray. It surprised me because actually when adults have depression they don't see themselves as the best, maybe they never are secure in themselves. Convincing them of this... demands your work. They are always predisposed to that 'no, everything is bad, no one can help me, if I do it, it won't work'" (Daniel).

As Patricio (psychiatrist) mentioned in his discussion of discerning how biological a patient's depression is, Patricio viewed depression as an illness. To be an illness meant that one needed to see an expert, explain their symptoms, and have those symptoms identified as a disease process in the body to be treated through medical interventions such as anti-depressant medications. To be an illness also implies that the experience is beyond the control of the individual, as something that must work its course through the body to be relieved.

Coming from a biopsychosocial perspective, Cristobal said, "I don't see only one reason [someone would have depression]. People have multiple aspects of vulnerability. One is development, psychiatric history. Also personal inheritances, and life situations. One can't say there is one singular cause." Like Patricio, Cristobal looked for biological causes of depression; however, Cristobal did not privilege potential biological causes over psychological or social.

Care providers most consistently expressed that depression had something to do with organic mechanisms within the body, outside the conscious desires or efforts of individuals. Care providers often spoke about depression as a process occurring within the physical body as part of a biopsychosocial process, where individuals have biological predispositions or risks which are triggered through psychological development or social events in one's life. Even within the biopsychosocial model, many care providers pointed to the biological elements of depression first and foremost. The biopsychosocial model is widely accepted within mental health, as mental illnesses are too complex to be explained by social factors alone (Kleinman 1988, Davis 2010).

Patricio, a psychiatrist, explained how he handled depression, elaborating that the first thing he wants to figure out is how biological an individual's depression is. "There are three big questions that one has to answer with the depressed patient. The first question is how biological

is the depression, that is, how much predisposition do they have, how much biological or genetic vulnerability can I see in the depression...” Similarly, Paula (a nurse) described the possible causes of depression as social, but only after a disclaimer that these are potential causes aside from the biological ones which experts would automatically take into consideration.

Patricio further explains: “So for me the point is, um, if there is a person that doesn’t, that produces this lack of vital energy, they aren’t capable of facing their situations, they are overwhelmed for this, for me that’s a depression. I always translate the patients, in my image, that I think also that the depression is an illness and that biologically is translated that the person isn’t capable of having the energy that they would have normally to face the challenges that they have in that moment in their life.” To Patricio depression was about energy level as a function of bodily processes, energy which would enable the individual to move throughout life’s daily rhythms and allow them to complete necessary tasks. When energy production is insufficient, people are no longer able to handle their day-to-day tasks and feel overwhelmed.

As part of the process of diagnosing depression, neither Patricio nor other care providers mentioned consulting the ICD-10, DSM, or any other psychiatric manual about the symptoms patients described to come to a conclusion about which disorder was the best fit. Within a biopolitical frame, however, the education and training mental health care workers receive which would likely include reading and working with such manuals is part of what designates such people as the experts. Holding psychiatric knowledge about different disorders enables care providers to quickly come to decisions about which diagnostic category would offer the best fit, as well as which remedies are most highly recommended based on the context of the patient’s symptoms; such speed is important within healthcare systems relying on efficiency. Such efficiency is important within a larger governance structure aiming to bring population health

under control. Experts within a biopolitical system are not only articulations of knowledge within such a structure but also a mechanism through which transformative tools are selected and applied. Utilizing pre-existing diagnostic categories has been charged as working against the health of individuals as it is an attempt to fit one's particular, unique, and extraordinary circumstances within the confines of a category which may not accurately portray or manage that individual's experience (Davis 2010). Biopolitical governance structures, with a focus on aggregated health management and the "making live" of the population, would not be as concerned with exactness-of-fit when good-enough-fit has been identified as remedying population health issues.

A social worker who was part of a traveling, multi-disciplinary team of mental health workers based out of one of the hospitals explained that such problems people face in their lives cause stress, which in turn makes people feel depressed. In her experience, most people with depression had some kind of family issue, whether it was strict roles, child abuse, or some other element.

"Always there are underlying motivations that happen because of important psychosocial stress. Many come for loss of work, loss of someone close, or stressful things in their lives, emotional things. Death of a partner. I have always seen people with depression, I don't know if it's this way, but those that have severe depression have very high emotional pressure from family. Generally this happens with dysfunctional families, where the roles are very strict, when there's a kid that is beaten or that are families where dad abandoned the family, or death, always there are problems in the family. Or may also be childhood trauma, sexual abuse... Family problems are risks for people" (Daniel, social worker).

While providers described some social elements to depression, treatments were largely around pharmaceutical, technoscientific interventions, and at times included psychotherapy. This contrasts with the social psychiatry movement in Argentina, which framed mental illnesses as the product of disordered interpersonal relationships and thus strived to rework those

relationships as healthy ones to alleviate or remedy mental illnesses (Lakoff 2006). In broader contexts, when providers acknowledge “life problems” as contributing to mental illness, this often refers to situations of poverty or some sort of disadvantage (Kleinman 1988), although Daniel’s account of “underlying motivations” matches well with how patients explained their own perspectives.

During observations of in-patient services, care providers also discussed the notion of individuals realizing they needed help, in terms of having ‘insight.’ Insight is a term in psychology meaning that a patient consciously recognizes some of their behaviors or feelings as indicative of a mental illness, as contrasted with either feeling those symptoms are normal or not associating them with mental illness (Castonguay and Hill 2006). Insight was often used as a measure of progress for a patient in treatment, where the more insight a patient has the better they are perceived to be able to manage their own mental illness and the sooner they would be to being released from in-patient treatment. Through a biopolitical lens, insight is a patient’s recognition of the distance between their own mental ill-health and what is required of them by society to optimize individual and population well-being. The use of insight as a measure of progress sociologically speaking represents the mental health professionals, as experts, evaluation of whether patients had appropriately adopted a biopolitical imaginary through which to assess and regulate themselves.

Salir adelante

People experiencing depression felt high pressures to *salir adelante*, or to move ahead in their lives without depression, as Gloria found in her experience in the in-patient ward. For some, this gave hope, and for others, hopelessness. “Many people tell you, ‘Yes, you can do

this, you can move ahead alone.’ And it’s not like that. It’s not like that or I would have done it already.” (Estefania, patient).

Claudia explained that she thought she had depression because “a lot of things have happened to me in my life that bother me!” She went on to explain that although she was having problems with her spouse and was being verbally abused, she never told her children about it in hopes that it would not affect them, and because she felt she needed to *salir adelante*. Thinking of what the best possible outcome could be for her children helped her to continue on in life despite the problems she faced.

One outsider recognized the difficulty of trying to move on in life, to get out of depression. “I think depression requires a lot of will to *salir adelante*, to do activities, there are people who pass by, I don’t know, staring at the ceiling in their rooms, without doing anything, without doing things, only thinking, thinking, thinking, thinking. It’s very different than the kind of person who plans, has projects, activities, has a more active life. I see it like that, that it’s a lack of energy, or personal reasons that can be very diverse” (Luz, outsider).

Salir adelante for many patients meant a denial of one’s own emotions or problems in an effort to carry on, especially with regards to the care-taking of others, as in Claudia’s case. By beginning to regain everyday routines and putting one foot in front of the other, patients hoped to lose their depressed feelings by focusing on the task at hand rather than dwelling in negative thoughts or emotional space.

The Role of Experts

From many of the quotes above, part of the advice for people had to do with finding the correctly educated and qualified individual to assist in recovery through a variety of therapies. Care providers such as psychologists and psychiatrists serve as experts in the case of mental

illness, and many participants expressed that those experts were a beneficial and necessary part of the recovery process. María (patient) described her situation: “I’m sick and I need someone to understand me.” María felt that the person or people who could understand her would be those within the health care system, as she saw depression as being an illness. Carla, another patient, explained, “What the doctor says is what I have to do, even if I don’t like him.” Because the doctor is seen as the expert in handling mental illness, this knowledge overrides any personal sentiment about the doctor. Carla’s feeling echoes the opposite side of Parsons’ functionalist analysis of health professionals (1951), who are to provide the best advice and treatment regardless of personal sentiments towards patients.

In addition to those statements signaling a reliance on experts for treatment, patients also come to understand their experience or diagnosis in a similar way. Florencia said, “[t]he doctor says that it’s a severe depression, for the mourning that I live.” Florencia recast her personal experiences through the label “severe depression,” the label the doctor used as the diagnosis for Florencia’s symptoms. Similarly, María knew about her condition through the communication she had with her psychiatrist: “I know what kind of depression I have, I know it’s major depression and borderline personality because that’s what my psychiatrist told me.” Patients’ knowledge and understanding of their own experiences being framed through what the mental health professionals have told them is a clear demonstration of a biopolitical articulation of knowledge through the role of those empowered as knowing the truth or objective reality related to a health condition.

Violeta’s family members, her husband and son, were quickly ushered in to the staff room and told, before being seated, that Violeta had been found with drugs the night before. This was cause for release even though she had not completed treatment. Violeta’s husband, who

appeared to be around 50 years old, had short, dark hair, a mustache, and goatee. He was clothes were clean and crisp; he wore a plaid button down shirt underneath a gray sweater, with green corduroy pants and a black coat. He rubbed his hands together nervously. Violeta's son was about thirty years old, wearing a yellow, long-sleeved t-shirt and black pants, with a black fleece jacket. Violeta's husband asked if she had to be kicked out. The head psychiatrist explains that she gave the drugs to another patient, to which Violeta's husband and son did not seem concerned. Her husband exclaimed, "it sounds like you're saying we brought the drugs in, but that's not true. We put our faith in it that she'd leave here [doing] well!" He was frustrated, saying he would have to get administrative leave from his job to take care of her. "You can't kick us out," he continued," because we're on PRAIS."²⁸ Violeta's son said it's a shame if she has to leave, while her husband continued on to say that the doctors, as the medical team, should see the situation differently; if someone does what she did, it's a sign they need help. The head psychiatrist attempted to explain that there is a certain structure to the in-patient facility and "we can't have certain patients here," but Violeta's husband interrupted: "you're the director... I trust in this hospital." He felt it was an aggression against him and his family. Where would they go? Why not another opportunity?

Violeta's son and husband protested further, bringing up another family member as Violeta's husband proclaimed "you've lied to tons of patients! We've been waiting five years for our daughter to be good and you've been lying to us because she's not fine. You're experimenting with patients! You have a methodology of making patients into liars!" One of the medical students finally interrupted, saying that Violeta is a risk for herself and for others, that

²⁸ PRAIS stands for Programa de Reparacion en Atencion Integral en Salud y Derechos Humanos (Program for Reparations in Comprehensive Healthcare and Human Rights); it is a health care program for victims of the dictatorship and their families.

she has responsibilities as a patient knows it. Violeta's husband retorted, "you're making a mistake to send her out, with risks!" Her son added, "you're making a mistake not to involve family more." The occupational therapist informed the two men that patients do not just leave, but that the team would follow up with them. Violeta's husband, feeling drained, said "a psychologist is important to the curing of my wife. What does she say about all this?" The head psychiatrist told him, "she agrees with us!" After a few more comments from Violeta's husband that he feels the decision to remove her was deceptive, he and his son leave the room.

Violeta was brought into the staff room after her son and husband had left. She said she thought it was only logical that she be released. She couldn't sleep the night before, felt alone, and wanted her feelings to go away. "I had such severe anxiety," Violeta said. The head psychiatrist asked her why she didn't talk to anyone, since there was no schedule saying she could not speak with a nurse or psychiatrist during the night. "I wanted to end my anxiety. The others didn't know I had pills. I don't want to leave. I can't be alone." The head psychiatrist said that she had to be released, and they would call PRAIS for an appointment in the next week. Somewhat defeated but sounding slightly optimistic, Violeta said "Seems fair to me. I have to take responsibility for it. I am scared to be in my house because I have to kill myself. I prefer not to talk about it because I'm useless. I'm useless, I'm good for nothing," she says, as she looked down at her hand, picking her thumbnail. Within ten minutes of her having come in the room, she is escorted out. The occupational therapist told the group it seemed clear Violeta was trying to manipulate the situation. The medical student charged with Violeta's care while she was hospitalized was concerned, saying she did not want to be responsible for someone who goes home and kills themselves, because that is a possibility. "If something happens, I'm the

medico tratante *[attending physician]*.” A loud cascade of “nos” came from the other care providers around the room.

Although Violeta did not admit to giving drugs to other patients in the last interview she had with the hospital staff, such actions could be seen as Violeta providing care for others in the in-patient ward, as she would have had little other means to do so, similarly to how some people from poor backgrounds in the La Pincoya neighborhood of Santiago would hang on to antidepressants to be able to provide for others in a time of need (Han 2013). Regardless of the reasons for which Violeta may have held onto drugs without the care providers’ awareness, she was perceived as acting out of line for taking charge of decision-making regarding her own psychological and emotional states. Indeed, the drugs she had hidden away could have been contraindicated with pharmaceutical treatments prescribed while Violeta was hospitalized; the combination may have proved fatal. However, the focus of the conversation with Violeta and her family was not about the danger of mixing drugs, but that Violeta had violated a tacit rule: patients are to rely wholly and exclusively on the advice of the expert, without self-determination to realize relief or wellness. The theory of biopolitics anticipates that there would be some people who held specialized knowledge and were empowered to do so; this knowledge in the hospital setting gave power to care providers as initiators of treatment regimes, and in the case of the in-patient clinic, that the providers were the only legitimate decision-makers in resolving the mental illnesses of those hospitalized. This overdependence on experts from the perspective of patients is more controlling than biopolitics constructs theoretically; instead, individuals are to receive information from experts but become self-reliant and responsible for their own care, in the name of what had been determined the good of the whole.

Nonetheless, Violeta's brief, intense educational experience of learning she should not have clandestinely kept alternative drugs with her while hospitalized is not incompatible with biopolitics. Rather, this experience could be seen as a mechanism through which the most "at risk" within the population are captured, kept, and made to recognize the importance of the authority of experts within a society remodeling towards a biopolitical orientation while also learning that it is the patient who is responsible for making decisions towards health. Simultaneously, the conversations surrounding Violeta's release asserted the special empowerment of care providers and the responsibility of Violeta as an individual in her overall health outcomes, as demonstrated by the surrounding practitioners' ardent opposition to the idea that a doctor is responsible for a patient's suicide when the patient is released before finishing treatment.

A social worker at one of the hospitals explained that he would rather work with someone diagnosed with psychosis, implying that those patients needing more than pharmaceutical treatments – such as those with depression – are more difficult to work with. "It's easier to work with a person with psychosis than a depressed person... they always have a need for psychotherapy, they don't take the drugs, it's much more complicated than you'd think" (Daniel, social worker). He explained that it was challenging to work with patients who have depression because of the interference in biomedical treatments. At times, Daniel explained, patients with depression did not understand why they would take antidepressants or did not want to take them, and the symptomatic negative outlook would hinder the treatment process. Abandonment of pharmaceutical use was common among depression patients Daniel worked with, which would cause the recovery period to lengthen substantially. Part of what made Daniel's work difficult was that patients would, at times, not act in accordance with what he had asked them to do for

their own health, which could be seen as an act of resistance to or a calling into question of his status as an expert within a biopolitical system.

Biomedical Intervention

In one of the hospitals where the head psychiatrist sees patients in his office, the doctor's office is a small, ten-foot by twelve-foot rectangular space, crowded with furniture. The psychiatrist's desk has two chairs on either side. The cabinets mounted on the wall at eye level behind the psychiatrist's desk house multiple books about psychiatry and mental health, and an entire cabinet space is heaping full with muestras – boxes of free samples of various drugs from pharmaceutical companies which had been tossed in upon receipt. A calendar on the bookshelf advertises Cymbalta; on the doctor's desk is a calendar for Aroxat (paroxetine manufactured by GlaxoSmithKline). The doctor's desk features a laptop computer set up next to a box of tissues advertising for Wellbutrin, and coasters from Pfizer. A year-at-a-glance calendar on the back of the door came from Globe Chemicals Company in Germany.

Throughout the course of observations, representatives from various pharmaceutical companies would come to speak with the doctors nearly once a week. The company representatives would come in between out-patient consultations for a brief visit of no more than five minutes, sharing a pamphlet about a new drug, giving the head psychiatrist promotional merchandise such as highlighters or chocolates, and inevitably ending in leaving some samples at the office, which the psychiatrist would store in a cabinet on the wall behind his desk. The heavy presence of pharmaceuticals within the space represents a new form of governance enabled by neoliberalism (Biehl 2006).

During one particular observation, two representatives from Pharmavida stopped by. Both women were dressed up in business attire, wearing black pants with fancy blouses and suit

jackets, carrying leather briefcases. The first representative came in, talked to the doctor briefly, handing him an 8.5 inch by 11 inch piece of paper titled “Bipolar Disorder in the Long Term,” and one box of a drug she said was to treat schizophrenia. The second representative came in and gave the doctor three boxes of a drug; he asked her if she could please spare one more box, and she readily pulled another from her bag, handing it to him. The psychiatrist was able to negotiate with the representatives about which drugs they would bring him, as on one occasion he described a patient’s situation which would be helped most by a drug that company offers, although it is expensive. The two arranged for a future date when the representative would bring several boxes of the drug for the patient. Several times throughout observations and interviews care providers explained that they were trying to do the best they could to deliver much-needed treatments and care to their patients, working within and sometimes around constraints of the health care system that limited which diagnoses would receive free treatments, and even then, which pharmaceuticals could be prescribed.

Aside from observing the pharmaceutical representatives visiting the hospitals, drug treatments were often the major talking point during out-patient consultations with the psychiatrist. New patients would get detailed instructions on how much and how often to take the drug they were prescribed – take one in the morning, one in the afternoon, and one at night, for example – and returning patients would discuss how well their current medication seemed to be working for them, often to have their dosages or schedules changed. Within the biopolitical system that had been constructed, the manufacturing transformative mechanisms had been outsourced from the government to corporations making pharmaceutical treatments. The brochures, fliers, and pamphlets the head psychiatrist received in one of the hospitals is

representative of the types of scientific knowledge that are helpful in defining the target of biopolitical governance.

Patients had mixed feelings about the pharmaceutical interventions with which they were faced. One patient, Carlos, believed the drugs very much helped him to feel better, but those drugs created an unwanted feeling of requiring the drugs to feel good or normal. “With the drugs that they gave me I feel really good, but the problem is that I quit taking them, and I returned, like, I went backwards. Like I depend on the drugs.”

One patient felt that pills worked well for a while, but she also disliked having to take them. “For two or three years the pills worked really well for me. Trying out different drugs and quantities never did good for anyone. I prefer not to take so many... It’s bad for the spirit” (Carla, patient).

In some out-patient interviews, patients told the head psychiatrist at Hospital Barros Luco that they had stopped taking medications because they began to feel better. The standard response of the psychiatrist was to explain his eyesight and the corrective lenses he wore. He would tell his patients that he could not see properly, so he got prescription eye glasses. When he wears he glasses, he is able to see well. Quickly abandoning pharmaceutical treatment for depression would be like removing his eye glasses because suddenly he could see again. The effect, the psychiatrist explained, is that because he was no longer using the glasses, he was unable to see. Wearing the glasses was required for him to see, just as using anti-depressants was necessary for patients to feel well.

The psychiatrist implored his patients to use the antidepressants beyond the time of experiencing symptoms; even when symptoms had subsided, one should continue to take the antidepressant as part of the patient’s management of wellness. Part of the transformation of

medicine and health through biomedicalization is the meaning and use of pharmaceutical drugs and treatment strategies, from having been used to subdue or eliminate symptoms for the restoration of health to a place where such interventions are used for optimization, enhancement, and preservation of health (Fosket 2010). Once the psychiatrist considered a patient stabilized, which was often several weeks or months beyond the report of no experienced symptoms of depression, dosage levels would slowly be lowered until the patient was instructed to no longer take the drug(s).

Aside from drug treatments, the other biomedical intervention that was used occasionally was electroconvulsive therapy, which was seen as the viable option when drugs were not effective, as in Gloria's case. When Constanza originally entered in-patient treatment, she was described as having pathological grief, which was described as a situation in which normal grieving has extended beyond the appropriate time frame. Constanza, previously described as having lost her son to cancer, told the care providers that she felt hopeless and wanted to kill herself. She felt she was not a good mother, because she no longer cared about anything in the house, including her four-year-old son. When the intake interview had been completed, the group discussed a proper diagnosis. One psychiatry student explained she didn't think it was pathological grief because Constanza wasn't expressing primarily that she was sad to lose her son; instead, perhaps it was a personality disorder. The head psychiatrist added his comments, saying that if Constanza did not get better they would send her to electroconvulsive therapy.

Ultimately, Constanza went through electroconvulsive therapy, almost welcoming the opportunity as a means to break her of her morose outlook through intervening in her body's ability to remember her son and what happened with so much detail. During our interview, Constanza said, "He was the pillar of my life... The doctors have told me I have to overcome

this, and that is why I'm in treatment. I want to erase a little bit of my memory, to see things from another intensity."

Biologically oriented, technoscientific interventions such as pharmaceuticals and electroconvulsive therapy target specific components of individual bodies for treatment in hopes that the effect will lead to an individual's wellness, or at least lessening of symptoms. Within the logic of biopolitics and the MIND Project, medicine as a social institution plays a role in the management of illness and recovery not only to enhance individual health but to enable the individual to engage in productive, paid work, to optimize society and its economic productivity as a whole. Health facilities are the physical sites where medical professionals work to create healthy, productive people through the use of biomedical interventions. Sociologically, that part of the focus of the MIND Project is the creation of an enhanced workforce to generate more money for society in efforts to achieve economic development, the process of treating depression through a focus on biological processes of the individual body by making use of pharmaceuticals simultaneously creates well-functioning or good biology as capital to generate wealth for society as a whole. In this way, the biomedicalization and biopolitics of depression create people with depression as biocapital²⁹.

Conclusion

Depression as a process or state of being within the physical body was expressed in a number of ways. Patients, care providers, and outsiders each had different ways of explaining depression being caused within the brain, body, or by genetics. Participants from all three groups explained that depression was an illness treatable through the health care system,

²⁹ This term is often used in a slightly different style, to refer to components of bodies, such as organs, bones, and blood, being extracted from individuals to circulate on the market towards the generation of surplus value (Sunder Rajan 2006, Waldbry and Mitchell 2007).

although patients were more attuned to nuances in how others interpreted depression and patients' experiences with it. In conjunction with depression as an illness, patients and outsiders including explanations of depression as caused within the brain, body, or by genetics; of depression as an illness like any other; of advice to others to seek professional help and therapies; of those professionals as experts about the unknown or not understood characteristics and best resolution for mental illness; and through intervention strategies oriented at changing the body using pharmaceuticals or through electroconvulsive therapy.

The meaning of "biological" has been explicated in various ways depending on the source of data. The discourse analysis from Chapter 4 found that the global texts defined biological where physical bodies are seen as machines with the capability to function, with depression working against those functions to disable or diminish the functioning of the machine (body) itself. The national texts analyzed in Chapter 4 collectively held biological as meaning depression was a cluster of signs or symptoms of the body, brain, or mind, as determined by genetics or neurochemical reactions; depression as biological meant that it was an illness caused by chemicals and components within the brain. In the context of observations and interviews, that depression was interpreted as biological meant slightly different things to various actors, but broadly could be defined as a sense of being out of control, influenced or created by internal physical processes related to one's energy level, similar to other illnesses, inheritable through genetics, and treatable through pharmaceutical interventions.

However, participants' ideas of depression do not match what one might expect from the WHO's emphasis on the 'trickle down' of mental health knowledge from global to local. The outsiders, a sample generated outside of the healthcare system, were most likely to express depression as relating to genetics and biochemistry, and explain depression as being endogenous.

In contrast, the patients understood depression as a malfunctioning brain or mind with few specifically relating depression to specific internal processes, although depression was felt to be a lack of control over one's mind or body to take part in the routine activities of normal life. Patients' accounts of depression included all four aspects of the ICD-10 definition: lowering of mood, energy, interest, and activity levels. That is, patient constructions of depression mapped well onto the standardized, global psychiatric definition of depression. These conceptions of depression somewhat align with those of the WHO's MIND Project, through the effect of depression as disabling bodies from their ordinary productive capacity.

Characteristics of each group of interview participants, such as age, education, and social class, may have also played a role in the ideas each group held about depression. For instance, the outsiders group was much more likely to explain depression as "endogenous," expressing that depression was a biological, pathological, inherited illness with genetic components, rooted in the brain. The group of patients, however, rarely referred to depression as biological aside from the idea of depression as an illness, or depression meaning being out of control. A major difference between these two groups is years of education. Whereas the outsiders group was made up of many university students and people with college degrees, the average education of the patients group was around or a little less than a high school education. The types of knowledge shared with the outsiders during the course of their education very well could have informed the perspectives they shared; it is possible that the outsiders, with higher levels of education than the patient group, had global psychiatric knowledge had come to them through the educational rather than the health care system. Higher education is also extremely expensive in Chile, to the point where violent student protests to reform education – with Molotov cocktails from a few met by police water cannons and tear gas for all – have erupted several times even

within the past five years (Taylor 2011, Henao 2012, Vergara 2012, AP 2013). The high price of education has meant that it is relatively inaccessible to people in the lower classes; it is possible, as many of the patient participants came from poor or lower-class neighborhoods that they did not have the opportunity to acquire such education.

Three components of biopolitical management systems arise within the context of this chapter: the role of science, reliance on experts, and depression as illness. Science was specifically discussed by very few participants but include one care provider referencing multicenter studies about depression's prevalence, and an outsider imploring hypothetical friends with depression to trust science to solve their health problem. That science was not present in most participants descriptions of depression demonstrates that a purely biopolitical notion of depression had not yet 'trickled down' to the level of the general population. With comparatively low levels of education amongst the patient group, it is conceivable that science was distant from the group's everyday routines and experiences and thus was not useful in considering depression. Comparably, in Japan, neurochemical explanations were too far from the experience or reality in which people lived; as such, people populated the category of neurochemical explanations with their own hypotheses or meanings. "[N]eurochemical imagery serves as an *empty symbol* (c.f. Barthes 1962) into which rich meanings can be inscribed, making local interpretations ever more diversified, creative, and evocative" (Kitanaka 2011:68, emphasis in original). Within the current project, explaining depression as an illness fills the space of the anticipated biological or neurochemical definition under a biopolitical governance structure, as illness is much more a part of general everyday life than would be discussions of dopamine, serotonin, or neurotransmitters. Constructing depression as illness made conversations about depression experiences as well as interventions helped to build depression as a more accessible

or familiar experience, as also happened in Japan (Kitanaka 2011). Depression has taken on an even wider meaning, which will be explored in the next chapter.

Patients, care providers, and outsiders all identified depression as an illness, as did the health care system through the inclusion of depression in the *AUGE* program which guaranteed care for over 50 of the most common illnesses Chileans faced. While the expansive *AUGE* program includes coverage of the most common conditions is about serving the highest number of people, not necessarily the most severe or debilitating conditions. Pharmaceuticals in Chile, as in Brazil in the case of AIDS (Biehl 2006), were an important component of how the state handled depression through *AUGE*. By allowing only a limited number of antidepressants as approved through *AUGE*, the state has created a specific pharmaceutical market, a “captive market,” as some may not be able to financially afford other options (Biehl 2006:222). The *AUGE* program may contribute to a condition-based “values gap” already present within the global pharmaceutical industry, which points to the discrepancy between populations who have access to treatments and can afford them, versus those people who do not have access or the means to pay for such treatments (Petryna and Kleinman 2006:6). If a condition is not covered through *AUGE*, it may be very expensive for patients to seek treatment.

Many patients and outsiders expressed the importance of relying on mental health care professionals to diagnose depression, prescribe treatments, and manage care. The role of experts in disseminating information and biomedical treatments, as well as others’ perception of the importance of this role within society, demonstrates biopolitical governance well. That mental health care professionals were seen as an integral part of the social structure is not exclusive to biopolitics; structural functionalist accounts of health and the institution of medicine also assign high value to care providers for enabling the population to continue fulfilling social roles and

responsibilities (Parsons 1951). What is decidedly biopolitical about the way in which patients and some outsiders expressed reliance on experts was the dearth of alternative solutions, and that consulting a mental health professional was the only way to access effective treatment. Educating one's self about psychiatry and mental illnesses was not an option; those who experience depression should consult with those who have the training to have been empowered as knowers because such training and status as health care providers deems their knowledge more valuable. Experts serve as gatekeepers to socially valued pharmaceutical and technoscientific interventions deemed as necessary in one's quest to *salir adelante*.

For those who had been in treatment for depression, most noted the importance of *salir adelante*. Moving forward in their lives was something they all aspired to do, although some held resentment at the statements they heard that to *salir adelante* alone was an easy task. Some mustered the strength to do so through thinking of their children, while others felt it was necessary to enlist the help of the health care system to move them along. Talking of the ability to go ahead, one foot in front of the other, gave hope to many of those who participated in the project as they imagined themselves in a happier state, regaining pieces of themselves they felt they had lost during their depression experience, once again able to enjoy life. *Salir adelante* is quite compatible with biopolitical governance, as individuals are trained by experts in how to manage their own health for the optimization of living. Individuals who experience depression are made responsible for their own "making live."

Within the individual explanations of depression, including causes and potential interventions, patients, providers, and outsiders had slightly different understandings of the disorder. Amongst the patient group, a pattern emerged in which patients felt the causes of depression were social, but required biomedical intervention to overcome. On the other hand,

the patient group often expressed depression as the emotional manifestation of underlying biological malfunctioning, but recommended more socially oriented interventions. Patients recounted the struggle of asserting their voice and experiences to others in attempt to be heard without being dismissed as lazy, insane, or weird. Mental health professionals in the settings navigated a space of being empowered to help patients through application of expert knowledge and asserting this position as expert as a more prestigious and indispensable part of the recovery towards wellness. Management of depression for patients meant regulating physical bodies and minds through technoscientific interventions designed to better enable the individual to survive less affected by their surroundings. As part of a biopolitical structure, such pharmaceutical interventions work towards the “making live” of individuals within stressful social conditions. Patients largely described their own experiences as related to interpersonal conflicts; an examination of the broader social context and its perceived influences on depression make up the topic of the next chapter.

CHAPTER 6: ON THE SOCIAL CONTEXT OF DEPRESSION

Many of the people interviewed for the project expressed that depression may be influenced by social factors. In this chapter, the focus is flipped to examine how social factors shape understandings of what depression is. That is, whereas the previous chapter focused on how people thought of depression as an illness, this chapter expands that scope to elaborate on depression in society, from social perception and stigma to widening definitions of depression and the notion that depression could be a way of life.

Social Perception and Stigma of Depression

Patients

People who had experienced depression at times felt understood, that the people around them were caring and sympathetic about their feelings of sadness and experiences with depression. For example, Estefania felt that most people had been well-educated about depression as an illness, leading to lessened stigma. “Chileans don’t discriminate against it [depression], because it’s a state in which more information has been given. What, what I have seen on television it’s a mental state. They’ve been informed around the topic so it’s not discriminated against anymore, like in other parts.”

More vehement, however, were the patients who felt that their own experiences with depression were dismissed or not fully appreciated by the people around them. For example, some feared that depression was seen as *locura*, as madness, incurable, and stigmatized. Stigma

held various forms: that others felt those with depression were faking an illness, that people with depression could easily snap out of it on their own or be cured through going out partying.

Marcela (patient) felt that people were talking about depression more in general, but that there was still a lack of understanding about what depression actually meant for people who experience it. “I think that the majority of people don’t, don’t understand it. They don’t understand. They talk about it more, but hey, it’s like they say suddenly not to have the problems that one has, and suddenly they understand. They understand no, you have to go out, you have to do this, not something else, and it’s so screwed up, that they don’t know what happens to a person.”

Isabel (patient) felt that others did not understand whatsoever what depression was for her and would question her out of disbelief. “Others haven’t experienced it so they don’t understand. When you talk to them, they don’t believe you.” Other people felt like she was inventing this condition. They would say to her that she was young, with children, so “how could you be depressed and want to die?” She felt often she was told her feelings were just due to a lack of effort not to feel better. Carla (patient) felt that society understood depression in a sense that “if you don’t get better, it’s because you don’t want to.”

María experienced similar reactions from others thinking depression isn’t a serious issue and simply going out to party and enjoy oneself would help someone recover. “The people who haven’t lived it won’t understand because society is like that. [They think] that one can get over it with going out, having a good time, that it’s not that bad.” The lack of understanding from people who had not experienced depression was understood by María as just a part of how the social world worked. María felt that others did not want to even discuss depression because it made them uncomfortable. “In reality it doesn’t interest them because it embarrasses them.”

What was worse for some people who experienced depression was that they felt that depression meant losing respect and even being criticized by those around them. Carla (patient) used to discuss her feelings of depression with others, but that has changed: “I wasn’t very reserved in talking about it but I realized that people don’t understand it and lose respect for me.”

“Other pe-, other people, like they criticize it [depression]. People are ignorant, they think they are normal, they think that we are crazy... Because when I tried to kill myself the first time... everyone was rude to me... [I was] shopping at the store and the woman criticized me. So I told her that she didn’t have a right to criticize me because she hadn’t lost a child. She didn’t know what I felt” (Florencia, patient).

Another patient, Isidora, thought depression was fairly common and on the rise in Chile, but she felt isolated in her experience. She said, “[it] makes me nervous because I don’t see anyone like me... For shame, or it bothers them and fear that they look at you like you’re crazy because they think depression is- the crazies have depression, they’ll say... [Others would say] that they’re crazy, that depression turns them crazy... that one lies, one does it to make themselves the victim, yes... to call attention.” Isidora felt that depression was a common experience to have but her lack of connections to others with similar feelings and problems made her feel that others judged her negatively as merely wanting attention.

The negative interactions and perceptions of other people about the patients’ experiences with depression were not explicitly described as stigma. Nonetheless, sociologically such circumstances can be categorized as stigma as the unfavorable beliefs of others helped to simultaneously distance themselves from people experiencing depression and make people with depression feel bad about their symptoms.

Biopolitics as a theory of governance is largely concerned with the relationship between power structures such as the state, on the one hand, and lay populations on the other, leaving no room to also consider how biopolitical governance affects the relationship between groups of lay people. As such, the original theory of biopolitics does not include a discussion of stigma although others have developed the notion of the “biopolitics of otherness” (Fassin 2001) to represent the ways in which biopolitical reductionism of individuals-as-biology and health-as-politics become inscribed on bodies, creating groups of people in need of intervention. The negative evaluations of some groups become justification for the types of restrictions and limitations placed upon those groups³⁰. Still, such limitations are granted attention as enacted through state mechanisms rather than informal techniques utilized by some segments of the lay population against others.

One component of biopolitics is that individuals will come to regulate themselves in accordance to designated standards of living, health, and wellbeing. If individuals were to identify strongly with the general population because of effective biopolitical governance, it is possible they would extend their own self-surveillance from individual-as-self to population-as-self; in such a way, stigma would serve as a mechanism used by some segments of the population to inspire adherence of others or ‘delinquents’ to common health standards or goals. For example, reactions to and shaming of obesity has occurred within the framing that obesity represents a lack of self-control that ultimately weakens the entire population; obese people have been bad citizens by not properly regulating their own bodies in accordance with what was determined as best for individual and population health (Guthman 2009).

³⁰ Immigration and racism are prime examples (Fassin 2001).

Providers

Care providers felt the general public had no comprehension of depression as it impacted the afflicted. They felt that others thought of depression as a made-up problem, or that it was not a serious issue for those who experienced it. Providers believed others saw depression as a sign of weakness or being lazy. Providers noted in general people struggled to fathom why some people would feel depressed, since so many people in society deal with similar problems.

“So, they don’t believe much in the topic of depression. They don’t think it could be an illness, or it overcomes an individual, [they think] that one can manage things alone. But they are like ahh, they have sorrow, I’ve been there, I’ve also been there, and they are done with you.. It’s like [they see it as] an excuse could be, or like, it’s like, a sign of weakness. How could it be for something so, simple?” (Carolina, psychologist).

Carolina noted that people who had not experienced it think depression is about being sad over relatively minor or even normal life events, without an ability to grasp why someone may seem to get stuck in a rut over aspects of living that everyone must endure. This could be one reason that so many outsiders relied on biological definitions of depression (depression as endogenous) as explored in the previous chapter. It also explains the perspective that Patricio detected amongst the population, that others felt sufferers of depression just hadn’t tried hard enough to move on. “I think that, that in society, I think that those who haven’t had depression have a hard time understanding what depression is... I think they see it like a, many people see it like a, like an incapacity of the person to confront life, like, like it’s the fault of the person.”

The reliance on the rhetoric of depression resulting from individual shortcomings and inabilities problematizes certain segments of the population seen as inappropriately or insufficiently regulating themselves in accordance with biopolitical goals. Framing recovery from depression as a matter of individual will could be an attempt to motivate people with depression to improve, but also works to uphold the biopolitical expectation of self-regulation

with the caveat that if someone does not actively choose to be healthy, he or she must be actively choosing to be unhealthy and perhaps they deserve to be outcast as they would be consciously choosing ill-health to the detriment of society.

At the same time, most care providers felt that depression was the socially acceptable mental illness to have, unlike other mental illnesses such as schizophrenia which were more highly stigmatized. Cristobal (psychiatrist) felt that to call mental illness depression was a means of taking an incomprehensible madness and making it understandable for others. “I think depression has lessened stigma, this stigma of psychosis. They say ‘no, it’s that I have a strong depression!’ To have depression was to have a psychosis.”

Daniel felt that there were still adverse connotations associated with depression, such as laziness, but that there were other mental illnesses much less accepted by society.

“[Others] don’t stigmatize it as much as other severe psychological illnesses. They don’t stigmatize it as much, but they see it as dysfunctional, like laziness. They are always saying ‘lazy, they don’t want to get up, don’t want to do anything, stay in bed all day, don’t want to go anywhere.’ Few have awareness of what it’s like for people with depression. They don’t stigmatize it as much as the schizophrenic, who is like the crazy lazy one who must be hospitalized” (Daniel, social worker).

It is possible that part of what made depression a ‘safer’ or more relatable mental illness was its construction as similar to a physical illness as discussed in Chapter 5, the inclusion of depression as one of only a few mental illnesses included in AUGE, and the types of education that Estefania thought people had received about what depression was.

Patricio (psychiatrist) explained that the stigma was not only a “spoiled identity” (Goffman 1961) for the one experiencing depression, but that stigma could lead to discrimination in the workplace.

“Before there was a very, very terrible stigma, I mean, in work settings... there are a lot of people who don’t want their medical leave to say depression because that meant that the next

time that they needed to reduce the employees, that they were going to let people go, ‘I’m going to be first on the list’ because, because they think that to have depression means they’re going to be less productive” (Patricio, psychiatrist). Patricio did not feel like that type of discrimination exists any more, in part due to the *AUGE* program.

Stigmatization of depression with the idea that people who experience depression would be ineffective workers fits well with the logic of biopolitics in constructing the health problem of an individual in terms of its economic effects on broader society, with specific concerns about how the illness of the employee would affect the potential labor that could be extracted from the employee. Even though having physician-approved medical leave for depression clearly indicates that an individual is working towards resolving their ailment by engaging with the health care system, depression as a mental illness is seen as a personal management issue that will continue to affect workers beyond the period of their treatment. Employer stigmatization of and discrimination against depression is about perceived risk to the employee’s productive capacity and thus to the employer’s bottom line.

Outsiders

Outsiders identified multiple perspectives with regards to social views about depression. A few expressed that most people understood what depression was like, while many acknowledged the critical, questioning, and potentially stigmatizing views.

Jorge (outsider) explained that he felt that depression was just something that didn’t happen to him or people around him, until he found out about a friend who had been unexpectedly diagnosed with depression. “The strangest thing for them was when the doctor told them that he had depression. It seemed like it could happen to anyone, but least of all to them... thinking in what they had told me, maybe I could have it too. Maybe it wouldn’t be so

strange...” Through seeing that a friend was diagnosed with depression it made the possibility of also experiencing depression less foreign, and somewhat less frightening. From what Jorge explained, having a friend diagnosed with depression could have welcomed Jorge to considering that he had depression himself, as sort of a social contagion. Within a biopolitical frame, this willingness for Jorge to consider that he himself may have depression is an extension of the management and regulation not only of self but of risk that he too could develop depression.

One stigmatizing perspective held by others in society and expressed by some outsiders in the project was a lack of understanding about why someone would be so distraught over seemingly minute problems, that things were not so bad, and that it should be easier to handle problems because everyone must, in one form or another.

“Depression is seen like a defeat, like a personal defeat, like a, a, a failure of not being able to continue, of not being able to continue and there isn’t a welcoming hand with depression. But on the other side, there’s a, there’s a critical view, right? Like the problem, all of us have problems, like I’m not going to be able to work and study simultaneously. All of us have at some time worked and studied, right? Depression because you have to [do both]? So there’s a loving, welcoming look that says, ‘poor thing, you have to, you have to put your problem in the hands of medicine, you have to help yourself, family has to help too,’ but on the other side there’s a certain critical, a critical view” (Vicente, outsider).

As Vicente described, socially there were multiple and conflicting views towards depression. First, depression was seen as an individual failing in life, which was met with contempt. Second, when viewed through a more empathetic lens, depression was something requiring a person’s reliance on doctors and medical advice and the help of others to ultimately help oneself.

Mariana, a student, felt that some who are diagnosed with depression enjoy the diagnosis as a talking point, feeling as if it made the person more meaningful to have someone spend time thinking about the individual and their situation. Mariana felt that depression gave a way for

people to call attention to themselves, to the point where people would say they had depression when they had not ever been diagnosed. Wanting to believe in this would then lead people to actually become depressed, in Mariana's view. "There are some people who like to say they truly have depression. Like yes, I have depression, it's like, they explained it to me, they diagnosed me, and it's like almost, eh, cool that they've told me I have something. Like depression. So for me, like, I feel like there are people that I know who say 'I'm sad, I'm depressed, I have depression,' that the truth is that no one diagnosed them except themselves, and they say it and I feel like they say it that way like 'I have something, like I want to believe it so much,' and that's how it actually develops." To Mariana, using the term depression to describe non-clinically diagnosed suffering was a sort of self-fulfilling prophecy.

Gabriela also felt that depression was seen as a tool for self-aggrandizement. In the past, depression was a way to draw attention to oneself. "I think that before it was considered more like a whim, like ay, that she's got, she's bored, she doesn't have anything else to be that would call attention, like that kind of thing" (Gabriela, outsider). To proudly announce one's status as having been diagnosed with depression in a biopolitical society, an individual could be doing the public work of demonstrating they are working towards health and contributing to society through its "making live" in a situation where others have devalued, delegitimated, and ostracized for their experiences in the past.

Medical Leave: The Stigma of *Licensia*

As I was sitting in the teacher's lounge of a local school in Santiago, in the midst of an interview with one of the teachers, she joked that she should go to the doctor to be diagnosed with depression so that she could get medical leave. Another teacher in the other part of the room heard this and commented back, "But what would you do with it, then?" "I'd leave on

vacation!” the first teacher said, laughing as she talked about how she could use the break from work.

Because depression is included for coverage in the *AUGE* health care program, a diagnosis of depression has the potential to come with a period of leave from work, as warranted by the psychiatrist handling the patient. In several outpatient appointments, those diagnosed with depression tried to negotiate with the doctor about the length of medical leave, including multiple requests for extensions. Medical leave was valued by patients while criticized by some care providers and outsiders, like the teachers mentioned above. The notion that someone would manipulate the medical system solely to obtain legal release from work implies that either the individual does not really have depression, that depression is not so bad for people who experience it, or that depression is merely medical code for laziness. All three

Daniel, a social worker, thought that people at times used depression only to gain medical leave to get out of working. However, those who do so are not without another diagnosis, he argued – personality disorder. Something else must be wrong with an individual to want to misrepresent themselves to be misdiagnosed for purposes of medical leave.

“Depression is very much in question in my mind for the idea of the medical leave. People with depression get leave... the leave without working, and this I see as an abuse of the concept of depression, and for this I always think they have a personality disorder. It has to do with that, and the people who have depression, they want attention, always. It’s better for them to be working... I think they have depression, but it’s that there is a diagnosis for several months, like a year with depression. I have a patient who has had depression for two years.”

The sociological concept of the sick role (Parsons 1951) helps to understand societal expectations and assumptions around what one should do when ill. One who experiences disease, disorder, or infirmity has a responsibility to care for their bodies to regain wellness, and

is socially allowed relief from normal obligations, responsibilities, and duties to do so³¹. Under such expectations, the idea of official medical leave as a protective mechanism to retain a job position is quite helpful. In the case of depression, however, the symptoms include withdrawal from people, activities, and the social world; as such, a component of many recommendations for recovery of wellness is to be more involved in activities and social events. This contradiction between the theoretical sick role and the specificity of depression has been called the paradox of depression (Karp 1997), parallel to Daniel's assertion that it is better for people with depression to be involved in work activities. Within a biopolitical society with the concern of individuals managing their health to enable productive contributions to society, the sooner one is optimally productive, the better.

An Alternate View: A Professional's Take on Depression in Society

Cristobal was a middle-aged man who had worked in medicine for nearly ten years, but had only spent the past six years as a psychiatrist at the hospital. He was inspired to work in mental health because he appreciated that mental health was more subjective; he enjoyed that in mental health part of his job was "to understand the world of the patient." Being able to explore cultural aspects related to mental illness was a part of Cristobal's job he found fascinating. A normal day for Cristobal meant arriving at 8:00 am, either to begin seeing patients or attend meetings with others on his mental health team, often working until 6:00 in the evenings.

³¹ The other two components of the sick role (Parsons 1951) include that the sick person should seek medical care and follow the advice of their doctor, and that it is socially understood that the sick person is out of control, or at least not responsible for their condition, meaning that the person experiencing sickness did not cause the sickness themselves. This second component is at odds with social perceptions of depression in this study, as depression was still fairly stigmatized and some outsiders thought depression was more or less consciously self-inflicted. Depression would fit into the typology of sick roles as an illegitimate sick role, as this grouping is reserved for stigmatized conditions for which individuals are viewed as at least partly responsible for their ill condition.

Between the meetings and consultations with patients, Cristobal would usually see twenty-six patients a week in the hospital and four or five more on days when he also worked at a local *consultorio*. “It’s a lot of work, but it’s very rewarding.”

In diagnosing depression, Cristobal would conduct an interview with patients. “With an interview you are capable of understanding the person, to relate to them and see how they are doing. At the same time you are asking how they are doing, you are analyzing it, doing a phenomenology of what the person is saying.”³² In Cristobal’s experience, “depression comes up as a secondary issue to other health problems.” Cristobal did not make mention of using an official diagnostic manual when consulting with patients, but with the larger mental health team in situations when they might need to use a manual, “it’s curious, it causes confusion for me... We should use the ICD as the international standard but the DSM has more status. I have no idea [why]. For me it has to do with the academic power of, of the north, of the United States... Before, European influence was greater. The ICD has less influence now, but most education programs try to include the ICD.”

Cristobal felt in general that *AUGE* was useful in giving wider access to health care. However, the large burden of mental illnesses in society was not matched by sufficient resources to help those in need. “*AUGE* gives access that is much better especially for people who didn’t have access before. In *ISAPRE* people already had access because they had their plans and could get services. The mental health problems in society are large, and the quantity of resources

³² This was exemplified well through the class for medical students observed at one of the hospitals, which was a course to refine interview and diagnostic analysis skills. Often the class meetings consisted of watching videos of interviews with patients, with pauses approximately every 60 seconds to talk about assessments of the individual, their pathology, and how their demographic characteristics may impact the diagnosis (as well as how, as care providers, to ask better questions).

reserved to tackle them are not as sufficient as the impact. There is a lack of development of resources... there are always few resources.”

The existence of *AUGE* complicated medical care for depression through its particular guarantees, such as acquiring an appointment within a certain time frame. Cristobal felt that the execution of the *AUGE* program was somewhat problematic, as he explained that hospitals were reimbursed for the costs of care for people with depression based on the number of people diagnosed. Additionally problematic was the fact that depression was one of few mental illnesses covered under the *AUGE* program, leading to people with other disorders to be diagnosed as having depression solely to enable those individuals to access some level of care that may help them.

“Today, it has to do with what you do in the program and it’s totally oriented around trying to diagnose and treat depressions because they are protected in *AUGE*. This means that the *consultorio* gets direct money for diagnoses. If you have an anxiety disorder, *AUGE* won’t cover it... If this person doesn’t have a diagnosis of depression, they don’t have a right to psychotherapy. And if they have a diagnosis of depression, they don’t have to pay. So put on the paper that it’s a depression. Because if you don’t, they won’t cover you. It’s totally for economic access to health care... I think that this happens a lot everywhere. It’s important to the population that they have the resources to tackle it. *AUGE* follows a biological logic, because it has much easier access to medications than other types of resources. For certain types of depressions, psychological services are not guaranteed.”³³

However, due to *AUGE*, the lay population had more access to information about depression because such information was more readily available at lower levels of care.

“People have more access now in the *consultorio*, and there are other intermediate institutions dealing with suffering. They already have an idea of what is causing the suffering, maybe their family. They go to see the doctor at the *consultorio*, the doctor says ‘how long have you been feeling this way,’ ‘maybe a month, a month and a half,’

³³ Similarly, Patricio (psychiatrist) agreed, noting he felt that depression was overdiagnosed. “I think there’s an overdiagnosis of depression, that whatever thing in this world from which a person has suffered, that makes them cry, that makes them sad, all of that is cataloged as depression.”

‘well what does that mean?’ ‘I don’t want to get out of bed’, ‘ahh, then you have depression.’ This is how the idea is transmitted. Chilean institutions permit that, that form of saying depression is suffering in general. Now it seems to me that of all the forms that are permitted that the depression is the most recognized.”

Cristobal pointed out a paradox within the Chilean mental health care system. As the MIND Project would anticipate, health care facilities should be a place where the dissemination of psychiatric knowledge about depression from care provider to the general lay population would be precise and clearly understood by patients and their families. However, because of what Cristobal identified as a lack of adequate training for non-mental health specialists in primary care, depression took on a wider meaning, leading to more diagnoses of depression when that diagnosis was inappropriate. In this way, Chilean health care facilities contribute to a “confusion” over what clinical depression is, thus advancing the expansion of the term depression in the social imaginary to encompass suffering in general.

“In general, [the population] view it as one of the various ways of suffering. Because of the majority, or in general, there is little repertoire of suffering. And suffering transformed into depression. Today it’s very easy to say that you have depression when in reality you’re sad. Depression is like the word that appears, it’s understandable for people. It’s seen as one of various forms of suffering... In Chile today, to be depressed is one pretty colloquial way of suffering... It’s not rare that there is confusion. The history of psychiatry is a little confusing, in that it’s changed over time... Today, many forms of sadness and feeling bad are depression... Everything is depression. In general, depression is like a common form of saying that one is having a bad time. The word ‘depression’ has many meanings, that for us signify the nosological, but to the culture depression is suffering. Depression is much more general.”

Cristobal believed that depression had become a slang term for suffering. Rather than its clinical definition, most people understood depression as meaning that people are having a hard time with something. This broadening of the definition of depression has worked to create confusion between mild sadness and clinically diagnosable depression.

Women's Experiences

After the regular set of Monday morning intake interviews with new patients, I walked back to the staff room with a group of three advanced medical students doing their rotations in the in-patient unit. As we entered the room, Alejandro set a small stack of patient files on the table in the middle of the room, and with a smile on his face said, "Being poor, having an abusive spouse, who is alcoholic. That's like, the typical story of depression here." The others looked at him, one nodded, and another offered a simple "yes," before they continued on with their tasks for the day.

Depression has been characterized as a women's issue, because women have been found to experience depression more often than men – usually at a rate of 2 to 1 (Kitanaka 2011). In 1999, the odds of women in Santiago experiencing depression within their lifetimes were four and a half times higher than that of men (Maier et al. 1999). A study from 2009-2010 found that while the national average of presence of depressive symptoms was 17.2%, there was a stark contrast between men and women: depressive symptoms were found among 8.5% of men but 25.7% of women (MdS 2010).

On the 5th of July, Gladys, a newly hospitalized patient, was to be interviewed by the doctors. She wore dark blue fleece pants and a lime green long-sleeved, oversized polo shirt. The baggy sleeves were pushed up to her elbows, and the collar popped up behind her neck. Her short, blonde hair was ruffled on top of her head and she limped as she entered the room to find the closest available chair to sit in. A ring adorned her left-hand ring finger and a pink paper wristband had been loosely fitted around her left wrist. Gladys told us that she was 52 years old and living with her partner and daughter. Childhood was not easy for Gladys. Gladys explained that she had taught herself how to read, but felt that was insufficient. Her mother suffered from

knee problems and uterine cancer starting when Gladys was eight years old. Her mother died when Gladys was 15, and shortly thereafter her grandfather and uncle also passed away. A man who had worked at her mother's business sexually abused Gladys; "I couldn't escape it." She had two children by him, who were cared for by her godfather.

For the past three years, Gladys held a janitorial position, cleaning buildings at night. About two or three weeks prior to this entry to the in-patient facility, she was fired because she had health issues that required her to take medical leave from work. Shortly before she lost her job, she found she was often fighting with her son. When she started to speak about him, she slouched forwards, crying, trying to talk. Gladys' son was addicted to drugs. "Excuse me doctor, the word is vulgar, falopa [hard drugs, usually cocaine]. All the strong drugs. He wanted to hit me. He called me names, perra [bitch]." He told Gladys she doesn't worry about him. About her son, she added, "it harms me to see him." This reminded Gladys of her own experiences with drugs; she explained that when she was 19 she was addicted. At 22 she got married and had her son, but soon separated from her partner because "he hit me, he beat me." Tears rolled down from the outer sides of her eyes and down her cheeks before she wiped them away, slowly and shakily, with her right hand. She told the doctors that when she feels upset, she will go to a nearby plaza, sit, and cry, or she will hit her head on the wall but nothing rids her of her rabia, her rage, her frustration. She has, from time to time, taken three to five days-worth of medication at one time when she felt very bad. She was hospitalized this time, she said, because she would leave her house on foot, walking for hours, without concern for how cold it was or whether it was dangerous. She went to the metro station recently during one of these walks because it was very close to her house. "I wanted to throw myself [in front of a train]," she

said; she had been feeling that way for about a month. “I don’t want to live. I don’t want to continue living, I’m bored.”

With the 8.8 earthquake at the end of February that year, Gladys lost everything so she went to live in the apartment of a friend’s father. She said she has a grandson, but the mother is a drug addict too. Before, Gladys felt she was a luchadora, a fighter, but she felt different at the time she was hospitalized, distraught that she had no explanation for why she had changed. “I’m like this, looking up. It is difficult for me to go out, it annoys me to leave.” Gladys has found that more recently she would drink water rather than eat, and that she was not sleeping well. “I wake up crying,” she said. She did not drink alcohol due to having high blood pressure. One week previously had cut her arms. “I ask for help because it is terrible to live like this.” She had tried many times to kill herself. “I don’t know why it hasn’t worked out for me.” “What is the biggest problem you are dealing with?” asked one of the medical students. “I don’t know how to answer. It was hard when my mother-in-law left because she was the only one who helped and understood me. She left seven years ago, she died,” Gladys said. Gladys wished she had someone to talk to, explaining that she felt embarrassed. “It’s terrible to be alone.”

The thoughts and experience Gladys endured are similar to those of other women experiencing depression. Women more often experience internalizing disorders, taking social or interpersonal problems as problems of self (Rosenfield & Mouzon 2013). “Women struggle with a greater sense of loss, hopelessness, and feelings of helplessness to improve their conditions” (Rosenfield and Mouzon 2013: 277)³⁴. Due to traditional gender roles and expectations,

³⁴ The flip side of this is that men more often experience externalizing disorders, with characteristics such as marked aggressiveness and interpersonal problems (Rosenfield and Mouzon 2013). Examples of externalizing disorders include alcohol and drug abuse. Men are

problems characteristically distressing to women with depression include relationships, illness, or death of a loved one (Kitanaka 2011, Rosenfield and Mouzon 2013) whereas men have been found to be depressed due to work issues (Kitanaka 2011); the women in the current study were often influenced by the death of a family member, as explained in the previous chapter. Women are prone to developing depression due to the powerlessness of high pressures at home and a lack of social networks or social support (Kleinman 1988). In times of stress, women express their feelings with others, seek out social support, and focus on changing their own thoughts and emotions regarding the stressor (Rosenfield and Mouzon 2013).

Examinations of gender within medicalization literature have largely considered how women's experiences of health and illness work to maintain gendered boundaries and identities (Clarke et al. 2010). Biomedicalization focuses more on how optimization and enhancement efforts both differ by and make use of gendered categories for effective governance (Riska 2010).

Estefania (patient) offered that she felt women's equality lead to higher rates of depression because of the second shift phenomenon (Hochschild and Machung 2012) – that women went to work to be equal to men but still have an unequal share of household chores and childrearing. “The way people live... We have a lot of worries, many, um, they aren't worries but as the role of the women now is to want to make themselves equal to men, give up being mothers and we have given up worrying ourselves... We have arrived to a stronger burden than we had hoped to have arrived. Because there are many women who can, who have a way to do it, but there are others who get overwhelmed.”

more likely to experience trauma due to higher involvement in violence compared to women. When faced with problems, men take a more active approach to attempt to resolve or accept the issue.

Although women had more opportunities in the workplace, they retained responsibility over domestic tasks; men had not yet begun to take an equal share in housekeeping and other work at home, which has been referred to as the stalled revolution (Hochschild and Machung 2012). In Chile, women's domestic labor was essential to political movements since the period of the dictatorship (Han 2011). Before that time, Allende had urged women to become involved in political social movements while valuing their roles at home, although this did not eliminate gender inequality or power differentials. The emergence of a biopolitical governance structure would play off of existing social relationships, something that Foucault did not entirely account for or predict. Whereas men's traditional roles rotate around the economic wellbeing of the family, women's roles are to secure the family's physical and emotional wellbeing. When a new system develops which emphasizes caretaking of the self as a central component not only of family wellbeing but the wellbeing of an entire population, in addition with requirements that one be economically or financially productive, women may feel increasingly responsible for the wellness of not only themselves but of their family members. In this way, because of historical precedent with regards to social expectations of women, the biopolitical structure saddles women with more of a burden to bear, which in turn would work to further solidify women's positions in the social structure. The dual expectation of enhancing the wellness of multiple other people and the valuing of optimal performance of paid labor could very well could, as Estefania suggests, lead some women to feel overburdened, stressed, and depressed. That such feelings would be reframed as a health issue originating from individual physical bodies means that through biopolitics, women are set up to be more heavily medicalized than their male counterparts.

The Normality of Depression

It was my first day in the psychiatric in-patient unit at the hospital. After a tour of the facility, I was escorted into the staff room. Six women sat around the perimeter of the room, all wearing white doctor's coats, hurriedly writing in patient file folders. I introduced myself quickly, and my presence hardly seemed noticeable to the others there. Within the span of a few minutes each of them finished writing notes and quickly left the staff room. The head nurse, who looked to be in her late 40s or early 50s, commented to me, "Depression is like cigarettes. It's fashionable right now." She continued on to tell me that people overuse the term depression, coming into the hospital saying they are depressed. Families are "dismissive," saying things like "oh, she just has an illness." She explained that AUGÉ allowed for poor diagnoses, but there are other reasons too. "Have you had a tour?" "Yes," I began to say, before she cut me off – "Let me show you."

From the accounts of some care providers and outsiders, it is easy to get the sense that depression has become a desirable way to express general dissatisfaction or suffering with one's place in life. Participants noted that ideas about depression had changed over time, leading to depression as "fashionable." Florencia, a patient, put it succinctly: "...It's an illness that is fashionable now... Well, everyone goes to the psychiatrist!" (Florencia, patient). In passing, one patient exclaimed, "We are the champions of depression!" She continued to tell me, almost boastfully, that Chile had the highest rates of depression in the world.

Care providers explained the popularity of depression as the consequence of historical changes in social perspectives towards depression.

"There was a shift, from when it didn't exist... up to a moment in which everyone is depressed, whatever situation that generates sadness, frustration, it wasn't to be depressed, up until a moment in which it was almost fashionable... that I have depression, I take fluoxetine... I think in general, the people have little consciousness of

what it is, they assume it as an illness, and treat it as such, and em, I would say that now there is more knowledge” (Ana, psychologist).

Patricio (psychiatrist) agreed that Chile and Santiago had been found to have high rates of depression, which he attributes to the dictatorship.

“There are multicenter studies that show that Chile is the country that has the highest index of mental health pathology, eh, and, compared with, I don’t remember which countries they were, but there are countries of, I don’t know, the first and third world... Chile and here in Santiago specifically had more, uh, more mental health pathology and also of depression. It’s not known why. There are people who postulate that... with the significant break the, the military dictatorship, with the breakdown of social networks, the breakdown of trust, so I think that with all the fear, the destruction of social networks, and with, I think the absolute exhortation of individualism, of oneself, of having things that generate frustration. I think those are the, the responses that would be seen in any minute of torture” (Patricio, psychiatrist).

Paula, a psychiatric nurse, felt that historically people had been more concerned about the welfare of others, but the military dictatorship changed the whole way of life for the entire population.

“People were more supportive, the people were more, um, there was a better sense of camaraderie, things weren’t so individualistic, and this wasn’t economic, it was more expensive, up until some very terrible things, according to my perspective... Well, after the whole period of the dictatorship, I think there was a change in the whole system of life and in the whole economic system. It was thrown out. Outside of it all, of all the human rights issues... there was a transcendental change... Something happened then that broke people.” (Paula, nurse).

Accounts of people returning from exile after the dictatorship have noted that instead of finding a society of equality, they had come home to a foreign society and culture operating under a new neoliberal economic system, individualized and isolated from others with undercurrents of authoritarianism requiring immediate adaptation to changing and changed environments (López Zarzosa 1998, Han 2011, Hirsch 2012).

The Modern Lifestyle: Isolation, Competition, Depression

During interviews, a few participants explored the possibility of Chilean culture contributing to the prevalence of depression either through societal norms of roles and responsibilities, or through cultural norms of appropriate behavior.

“I think there are certain cultural patterns that have given me the impression that foster depression but that don’t come given for the meaning that depression has, but for the problems in our culture. To work many hours, for us is like part of our culture. To not say things directly is part of our culture. To keep things to ourselves isn’t being reserved, it’s also part of our culture. None of those things help so that the people protect themselves, you could say... Also, our way includes our family ways...we have a culture where maternity is very valued” (Ana, psychologist).

Ana noted that there are many components of Chilean culture that could contribute to depression although they may not be interpreted as depression because culture is part of a normal or usual way of being, whereas depression as a category of mental illness problematizes behaviors and thoughts as unusual, problematic, or abnormal. Cristobal (psychiatrist) held a similar view: “For me what is interesting to know is whether the cultural aspect has an effect too. In schools they diagnose depression, and they say because ‘this guy is Chilean, and Chileans are like that!’ The Chileans are like that, subdued, also there is the cultural issue. It’s not a diagnosis because they said it’s not an illness, it’s their way of being” (Cristobal, psychiatrist).

Similarly, Camila (outsider) felt that Chileans had a propensity to be depressed because of their way of being. “I think that Chileans in general have a tendency for depression... Chileans are a bit more like, keeping things inside, to themselves, they can have a tendency towards sadness and therefore to be depressed.”

The tendency, as Camila describes, for Chileans to be sad and depressed was interpreted in another way by some interview participants who believed that society had progressed to a point where most people with depression no longer recognized that they were depressed. Rather,

the characteristics of depression such as a negative or pessimistic outlook, were thought of as merely one's way of being. It is almost as if, through the pressure of historical changes to the social context that structurally restricted opportunities and kept people from connecting to one another, that depression became so socialized as a way of being that it is taken as a natural existence or personality type.

From discussing how changes in society may influence depression, some went so far as to say that Chileans were naturally a sad bunch, inherently predisposed to being depressed. Interestingly, though, is that this natural tendency is understood as brought on by social structural conditions such as widespread lack of opportunity or unemployment. Paula explained this: "Chileans are sad people, because of the climate, and a lack of possibilities. There's an economic problem, that there are many who have a lot and those who have nothing. There's a lack of opportunity, work." She felt depression was worst in the middle class, and that because of poverty much of the population faced severe problems in life. "Well, outside of the reasons, right, that are biological, I think about the social contexts in which some live in our population. I mean isolation, unemployment, poverty, drug addiction, those would be some of the factors that I think that are predominant in those people for whom depression appears" (Paula, nurse).

When asked about the percentage of Chileans who had depression, numerical responses varied from five to one hundred percent but the overall consensus from outsiders and patients alike was that depression was very common in society. Several people explained that they got their impression of the prevalence of depression in the country from examining the social world around them, including seeing other people on the bus, in the subway, and out in public. The few who noticed these places mentioned that people in those contexts appeared sad, stressed, and "gray."

“I believe like 20, 30 [%], [prevalence is] high! Because.. it’s like the impression on the metro, when I see people I say shoot, people are so stressed, sad, like there’s no conversation, like to solve problems in a non-aggressive way, like, everything is, everything is so aggressive” (Gabriela, outsider).

Camila felt that simply being in public it was possible to assess that the population was depressed, but she argued that many people didn’t realize they were depressed. “Now many people don’t know that they have depression, or they don’t show it, neither do they inform anyone about it... It could be five percent [of Chileans have depression] because people you see on the bus for example, in the metro, the people look depressed” (Camila, outsider).

Many said the contemporary lifestyle created people who were stressed and with little time to relax, in a society marked by individualism, competition, and weakened social ties. These perceptions of the way of life are similar to neoliberal subjectivity found in Argentina: “[n]eoliberal subjectivity includes skepticism, individualism ... and a perception of the other as a potential competitor” (Lakoff 2006:70).

Emilia (outsider) felt that the sense of depression as just the way things are is due to a feeling of helplessness that people cannot achieve more in life. “There are people who don’t know they have depression, I think, that to be in this state like that is normal. I think, I think that this happens to a lot of people, a lot of people in that regard have to have that illness... They continue knowing, pretty resigned, that they have a family, they have to work, could be for someone else and not for themselves.”

Emilia’s assertion that it is not only about not achieving but that people may feel helpless due to working for another person resonates with Marx’s alienation, the idea that through engaging in wage labor within a capitalist system, where an individual is working not for

themselves or their human needs but for the creation of surplus value for the owner of capital, people become alienated from themselves, from their labor, and from the species as a whole (Marx, Engels, and Tucker 1978; Marx, Engels, and Milligan 1988). That people would feel resigned to the conditions of their lives without connection to the idea or reality that many others share this fate is a good illustration of false consciousness.

Vicente felt that depression was an effect of the competition in life. “I think that, eh, that the cause of depression, the principal cause of depression is eh, the lifestyle that is offered, that we, that we are offered that is a life that is a, is a model of life with, with a lot of competition, concurrence with, with much stress, right? Eh, and from this generates levels of, of, of stress and of, of depression, I think” (Vicente, outsider).

The sense of competitiveness was well-elaborated by Luis (patient). “I think that some ninety percent of the people have depression today... because there are people who, who want to be higher above the rest. So they don’t see that we’re all human beings. And that we all are, we want to have a family and a good job. But those people don’t think about that, and try to go surrounding and surrounding from all sides and hoping you’ll surrender, and just fucking everyone over, fucking everyone over, and fucking everyone over. That’s how, how the people are oriented... for their own benefit.”

Matias similarly felt that life was more competitive than it had been, and that life was moving at a fast pace. “Well, here, life is pretty complicated and the lifestyle here in Chile is very accelerated... We were more peaceful... with what we had, we lived very peacefully. And the environment changed, and it’s very competitive [now]” (Matias, patient).

María felt that the prevalence of depression in Chile was extremely high because of the contemporary lifestyle of most Chileans, living in a fast-paced environment as Matias explained.

“In percentage, today, 80% of Chileans [have depression]. Why 80, why this number, because we are living very accelerated, we aren’t living peacefully, I mean, we live very pressured, with work, family relations, in the home, everything is fast... People used to live in the moment. Now everything is accelerated, fast, anxious, nervous. We’ve lost sensibility. Formerly, people lived slower. Now it’s very accelerated and that produces a stress that produces depression which causes self-destruction” (María, patient).

Guillermo (patient) said he thought that all Chileans were depressed, which he attributed to economic problems in that it costs more to live than one earns. “That’s why there’s so much suicide,” he said. Estefania agreed, saying, “Of 100%, around half I think [have depression]. 50%... because of the life that we lead. It’s very fast-paced... Many people want to have what they don’t have” (Estefania, patient).

Vicente, an outsider, felt similarly that previously there had been an emphasis on people and their wellbeing, but that now people weren’t able to connect their own issues to those of their neighbors. Not feeling connected to the larger social body, according to Vicente, lead to feelings of pain, suffering, and depression.

“Life was more focused in the, in the people, right? In collective solutions, right? Take the people out of the situation of poverty and that, right? Achieve that all young people have the same opportunities. It was, it was a world more, more, more collective, more social, more socially collective, where my problems were connected with the neighbor’s or the problems of the neighbor out front or my school peers, right? Today no, today, today no, they don’t see the connection, of my problem and yours, between my problem and politics. I don’t know how, for example, public policies can affect my life and if I don’t know, it doesn’t interest me. This, this form of thinking has expanded and I think that produces a lot, produces a lot of pain” (Vicente, outsider).

Like the group therapy lesson which asked participants to compartmentalize pieces of their lives to better determine how one could take control over those pieces, Vicente’s perspective emphasized a reversal of the sociological imagination. This reversal, brought about

by social change, causes harm to people because they are not able to see how their private problems may actually be public issues.

The types of changes in life that were believed to bring about depression were described as a fast-paced, competitive, individualistic life, with fewer and lower quality relationships and communications with others. Many of these characteristics are part of modernity, or as Durkheim (1997) would argue, the shift from societies of mechanical solidarity organized around kinship to societies of organic solidarity organized around the division of labor in society. The consequence of the characteristics of life in modernity, as described by some of the people who were interviewed, include feeling overwhelmed, hopeless, and disconnected from others around them. Large-scale social change, including modernization, has been connected with increases in mental illness (Kleinman 1988). Durkheim (2013) expected that through vast and rapid social change, some people may feel they no longer had a connection to the society around them, which he called anomie. Sociologically speaking, the characteristics of anomie overlap substantially with descriptions of depression; if severe social changes inspire feelings of sadness and loss of interest in activities, depression serves as medicalized anomie. A biopolitical governance structure would work to recapture those people who felt lost, through a reassertion of how an individual could continue to work towards a common goal, interdependent with others in society. The regulatory mechanisms through biopolitics create a safety net for anomic individuals to learn a new sort of social cohesion for the optimum functioning of society.

María felt that many people in society had depression but used other coping mechanisms than the health care system and psychiatric care. “There are people out there that do drugs but really they do drugs because they are depressed and need an escape. Everyone has a reason. *Do you think those that have depression know they have it?* Many ignore it... it takes a lot to

survive.” María points out that life is difficult for many people, and drugs become one mechanism through which people feel they have an escape from the challenges of everyday living. To come to terms with having depression, María reasoned, would add one more stress and complication to the challenge of survival.

Luz felt that the prevalence of depression was high, although people did not recognize that they were experiencing depression because of a conflation of the symptoms with one’s general way of being.

“I think one super important thing is that, I don’t know, uh, I believe that many people have depression and don’t know it. Or they don’t realize it. They don’t realize it... Sometimes it’s a little confusing because it could be, could be that the person, their personality is that way. Like everything is negative, everything sad, as if nothing, nothing could be good. Because I have a friend who had a negative attitude towards everything. Towards people, towards everything, and one time I told him you could go to a doctor, and see if you have depression, and everything, but he said ‘no, I’m fine,’ so I think that many people probably have depression but they don’t want to realize or accept it” (Luz, outsider).

Veronica felt that everyone leaned towards being depressed. “So, also we have to know what, what is being called depression. I think that in a certain way, we all have a small depression, in general everyone has a tendency for a little depression but it all depends on the vision we see of depression” (Veronica, outsider).

The critical gaze of the interview participants towards depression’s presence in society as well as the multiple claims that people may have unrecognized depression illustrates how people search for depression within their everyday, routine activities and lives. Normal existence was called into question through the notion that everyone was at risk of becoming depressed, which has been called the “problematization of normal” as part of biomedicalization (Armstrong 1995, Fosket 2010). Participants were on the lookout for indications of depression in others through expectations of certain assumed-normative social-behavioral cues, such as smiling, interacting

with others in public spaces, and expressing a positive attitude. The entire population is not only subjected to but engages in practices of biomedical surveillance, a type of aggregate self-regulation one would expect within societies governed through biopolitics.

Han (2013) found that within a poor neighborhood in northern Santiago, people struggled to adapt their bodies to the pace of social and economic change. The physical and psychological consequences were interpreted as being caused by “specific life conditions produced by ‘the system’” (Han 2013:292). Another woman in this neighborhood felt disconnected even from the children in her own house, that communication had become difficult, and more generally that individualism and consumerism had become rampant in society. The individualized effect of these social changes was referred to by the woman as “neoliberal depression” (Han 2012:131).

Conclusion

Depression as a social entity took on a number of meanings for participants in the project. Across people diagnosed with depression, care providers, and outsiders, all understood depression as being about a profound sadness and lack of wants for engaging with people and activities. The accumulation of a variety of life’s problems was a weight too heavy to bear for some, leading to a “break” as described by Carmen, in which people feel overwhelmed, out of control, and saddened. In several cases, as extreme examples, people experienced the loss of a loved one which sent them into a state of not knowing what to do. People with depression mostly felt as though others around them did not understand what they were going through, leading to criticism, loss of respect, and in some cases, ostracism. It is somewhat surprising that a health condition as “popular” or prevalent as depression was would still carry a stigma. Biopolitically speaking, the stigma surrounding depression may function as a mechanism between lay groups to reinforce the self-regulatory expectation of governance.

The overall perception of depression in society was that it was on the rise, that more and more people were experiencing it as time moved forward. Multiple explanations helped to illuminate this perceived phenomenon. Depression had become the “fashionable” mental illness thought to have increased through television coverage on the issue and health care institutions’ broad application of the clinical diagnosis to cases of mild suffering. Some outsiders held the impression that depression served as a tool through which people could publicly claim a unique sense of identity, as if for show and attention. The perceived popularity of depression could be cause and consequence of public health initiatives for the disorder, targeted at the entire population.

Many noted differences in contemporary society that could lead to people feeling more stressed, and in turn, depressed. Examples include that life felt more fast-paced, that people were more competitive with each other, and that the hours and demands of work had increased. Some care providers felt the Pinochet military dictatorship was responsible for significant changes in contemporary society. During that period, as explained by Patricio, the repressive tactics of the government worked to instill fear in people, and this fear along with direct violence led to a destruction of social ties between people as they once existed. New social relationships had to be configured during that period, in a way that was compatible with the repression of that era. Based on the narratives of some of the interview participants, it is possible to say that perhaps those new ways of being did not end with the dictatorship in 1990. As Ana noted, present-day interactions are marked by keeping things to one’s self and not saying things directly, both of which would be individual management techniques to aid survival and avoidance of torture under the dictatorship. Rather than temporary solutions to a historical moment, these interaction techniques may have become more permanent aspects of Chilean

culture. Many of the social changes that occurred in Chilean society seem to match with characteristics of modernity (Durkheim 1997) although they may not be unique to Chile. This relates to Durkheim's notion of anomie, where individuals feel a lack of attachment to the people around them and thus feel lost. The dictatorship, with its repressive tactics and reliance on social networks to find potential enemies, could have sped up or made more permanent the sense of disconnect and individualism that was required for survival. People in China, during and after the Cultural Revolution which was also a period of vast social and economic change, upheaval, and government repression leading to a sense of disconnect from and distrust of others (Lee 2011). Neurasthenia arose during and after this period as a somatic mechanism through which people could express dissatisfaction in life (Lee 2011, Kleinman 1982). Perhaps it is in a similar way that depression arose in Chile.

One large difference between participant groups that may have impacted their perceptions of depression and social change was age. The average age of the outsiders at the time of fieldwork was 29, meaning the average year of birth was 1981 – eight years after the start of the dictatorship and nine years before it would end. Most of the outsiders, if they were born, were barely reaching awareness by the time the dictatorship was over. The types of neoliberal reforms and logic Pinochet and his Chicago Boys enacted in Chile would have been normative, standard practice for most of the outsiders; this includes the notion that individuals are responsible for their position in life, and must work hard to succeed. The infusion of neoliberal logic in thinking of mental health and depression may help to explain why many of the outsiders could not comprehend sadness in the face of material wealth, as well as how depression was stigmatized as something that one could snap out of, if the desire was truly there.

What is most interesting with regards to the perception that contemporary lifestyles may cause depression is the accompanying notion that due to the style of life people were living, depression was an incorporated piece of that picture. That is, that depression was just a way of life, so mundane that it would be unnoticed by many who experienced its symptoms, is a profound statement. People may not be able to recognize their lack of desire to participate in activities or to engage with other people as anything beyond the ordinary. In some ways, this could mean that depression would be a biopolitical success from the standpoint of societal management; that people just understood depression as something that must be dealt with, that must be medically managed meant that they were looking out for the good of the whole through working on themselves.

CHAPTER 7: BIOPOLITICS, BIOLOGICAL CITIZENSHIP, AND BEYOND

This chapter sets out to provide answers to the primary research questions, to examine the degree to which biopolitics and biological citizenship are useful theoretical frameworks based on the ethnographic data collected for this project, and to push these theories beyond their limits to more adequately capture the social phenomena observed through the course of this dissertation project.

The first research question sought to discern the extent to which the MIND Project was biopolitically oriented, which was explored in Chapter 4. The WHO and MIND Project texts included in the discourse analysis laid out a plan for tackling mental health challenges, including depression, with elements corresponding to each of those found in Foucault's theory of biopolitics. That is, within the WHO framework, depression and mental illnesses were constructed as population-level problems that were simultaneously biological, scientific, economic, and political, including mechanisms both to measure the extent of the problem and to intervene in depression as an illness process.

The second question engages with the notion of the "truth discourses" of biopolitics as constructions of the essential characteristics of human beings, including those people deemed experts who hold ultimate knowledge about such characteristics. Biopower, as the management of life, defines what these essential characteristics are; through biopolitics, the fundamental traits of humans would be related to biological processes within the body that help individuals to achieve maximum functioning within the economic system. This set of questions, asking about

professional practice as well as individual subjectivities of people diagnosed with depression, focuses on how much the logic of biopolitics has ‘trickled down’ as suggested not only by the WHO but by Rabinow and Rose (2006) as well.

Professional practice was very much shaped by the truth discourses about depression, best exemplified by Patricio in Chapter 6 as he described the process of first analyzing how biological a patient’s depression was. Several of the offices in the hospital where patients would be seen had bookshelves filled with texts on mental health, psychology, psychiatry, and even copies of the Diagnostic and Statistical Manual (DSM). There was no clear consensus across care providers about whether the standard was the DSM or ICD, some care providers felt the DSM was more influential because of the perception that the US was a global leader in knowledge and politics. When I asked the head nurse about this, she asked if the DSM was from the United States, and upon confirmation exclaimed, “Oh, we’re so *McDonald!*” signaling a frustration with having adopted yet another aspect of the US into Chilean culture. Intervention strategies for the most part were short meetings with patients, followed by prescriptions for pharmaceutical remedies, also falling in line with the truth discourses about depression.

The participants in this project all identified depression as a major health concern for the Chilean population; participants within this project felt mental illnesses were related to biological processes in the body but largely brought on by external, social stresses. Care providers and outsiders were much more likely to explain specific biological mechanisms and processes related to depression whereas patients felt depression was a loss of control over their minds. Participants in the project who had been diagnosed with depression did not explain depression in line with WHO-established truth discourses, but rather interpreted depression through the lens of the social context in which they were each embedded. The only overlaps between the truth

discourses and patient narratives of depression were the ideas that depression was a major public health issue for the Chilean population and that people with depression should get treated through consultation with mental health professionals in a health care setting.

The MIND Project elaborated both depression and poverty as conditions arising around individuals in isolation from social or political context, casting those who experienced the disorder as largely responsible for their fate. Such a construction of mental illness means that individuals are instrumental in initiating their own recovery process through the health care system. Most people who were interviewed as a part of the project felt it was imperative for those with depression to seek care from a mental health expert within the health care system, representing another match with the truth discourses around depression.

A major difference between patients on the one hand, with care providers and outsiders on the other, was average years of education. Generally, the non-patients had higher levels of education and could have been exposed to theories and ideas about depression through their coursework. Patients' educational attainment ranged from dropping out of middle school to attaining a doctoral degree, although on average the patients had about a high school education and may not have been exposed to the same ideas about depression during their educational careers. Interestingly, even with involvement in the second level of care – a more serious level of care than where 90% of people with depression are treated – patients did not conceptualize depression as biological in the ways elaborated by the outsiders, care providers, or the WHO. The truth discourses about depression as a biological process in the body had not trickled down to the general population through involvement in healthcare as the MIND Project had anticipated.

Truth discourses within the MIND Project also posit that depression has economic effects in increasing the likelihood that sufferers will be in poverty, unable to work, or unable to be productive when at work. Few participants spoke of the economic effects of depression on society in the sense that depression causes lost productivity and lessened income. The perceived effect of many people developing depression was that depression was normalized to the point where (1) depression was a general term for suffering, and (2) some felt the symptoms of depression had become a way of life, unrecognized as an illness.

Outsiders and care providers suggested the possibility that people with depression may be fabricating or exaggerating their symptoms to receive medical leave from work, which was interpreted as an effect of laziness or not wanting to be well. In contrast, patients felt that such perceptions continued to stigmatize people suffering from depression as they felt it was not easy to overcome depression or ask for help. This tension between the groups about the proper course of action in recovery from depression works against Karp's (1997) paradox of depression. Whereas society's expectation for the sick role is that people who are ill will abandon their normal responsibilities and duties in an obligation to make themselves well, depression as an illness requires that people become more engaged in their social world and work harder to keep with their normal responsibilities (Karp 1997). The patient participants in this study would not disagree that they needed to regain their ability to manage their daily routines and interactions with others, but they felt that the dismissive attitudes of others seeing depression and medical leave as laziness did not allow them to connect with other people in a way that would aid their recovery. While this topic was about the avoidance of work, for outsiders and some mental health professionals the issue was the perception that some with depression were lazy, not that

they were detracting from the larger economic momentum of the population as the MIND Project explained.

Rather than discussing large-scale economic consequences of depression, some interviewees felt the economic system itself inspired depression. Vicente (outsider) provided the best explanation, that the capitalist system established in Chile motivated people to acquire more and better material goods in pursuit of happiness, and that through capitalism the only way that one could achieve happiness is through conspicuous consumption and social comparison to feel better off than one's peers. Within this system, people are required to concern themselves with work and even working long hours would not pay enough for the lifestyles that are valued in society. Capitalism motivates people to participate in consumption in attempts to be happy, although Vicente felt instead that people were set up to fail and thus feel depressed as the competition of capitalist consumption was "damned if you do, damned if you don't" experience.

"...Depression is created, and many times for personal reasons, for money, for access to goods that you don't, that you can't access, no? It's madness but it's true, isn't it? You go to your friend's house and your friend has ten plasmas [televisions] and you have one and it's cheap so that creates many problems for you, you want the type of life that they sell you, that it's supposed that you have to buy to continue participating... You see it in your friends, I see that some depressions happen because of the type of life [that they lead]. You don't understand how intelligence, cunning, to discriminate, to understand that, if you're not going to be happier if you go with everyone to Miami, neither will you be happier because you moved to a nice apartment, you moved to a magnificent house, you know?.... The world invites you to participate, participate! It's very important that you participate because if you don't, you won't get anywhere. So you have to participate, you have to accept the idea of consumption and if you get sick it's better yet that we consume, you have to acquire skills, a profession is not enough, two or three, that is necessary in the future that's coming... This I think generates a lot of, generates stress, you see? This provokes a lot of those health problems, and depression is a health problem in Chilean society... You never get there, always they tell you about a prosperity, that never comes" (Vicente, outsider).

He continued: "It's a society oriented towards being productive. To be productive, that is for me a stress, stress is frustration, frustration, uh, is depression. I think the grand majority of

depressions are associated with the lifestyles” (Vicente, outsider). Several other outsiders, such as Luz and Emilia, felt that economic problems within one’s life could cause one to feel depressed (see Chapter 5).

The third question considers the shape of biological citizenship in the context of depression in Chile. Rose’s (2007) conception of biological citizenship as the outcome of socialization within a power structure utilizing biopolitics means that individuals within such a context should express their concerns in terms of problems in biological processes that are interpreted as illnesses. As citizens, in Rose’s conception, people would also make demands upon the state as the primary agent of governance to intervene on behalf of the population’s health. In addition to examining how biological citizenship appears in this context, there is a second question of how individual social locations intersect with biological citizenship.

Participants who had been diagnosed with depression, for the most part, felt that depression was an illness and that society viewed depression in that way as well. Aside from this description, though, patients did not describe biological processes or functions that had been disrupted. Patients described wanting to stay in the dark, wanting to sleep, wanting to cry, and wanting to stay away from other people, and these new desires to withdraw from the social environment made up most of what patients defined as the symptoms of depression. Under the category of illness, depression being treated through the healthcare system made sense to patients.

The second component of biological citizenship is the claims-making of individuals suffering from an illness on the national government, that the government is responsible for the health and well-being of the afflicted. All of the patients interviewed for the project were receiving free health care through government programs, either through the *AUGE* program

previously described, or through *PRAIS*, the health care program providing services for torture survivors of the dictatorship and their families. While the patients saw their health care as important in trying to get back to their normal lives, none expressed a sentiment that it was the obligation of the government to care for their health. Only Vicente expressed something close in his statement that if he were to become depressed, he could do so “calmly... because the illness is financed.”

Chile’s recovery from the totalitarian, repressive governmental regime could be playing a large role in the seeming absence of biological citizenship. The dictatorship represented a time when the general population experienced a “cultural blackout” (Timerman 1987) and large-scale fear of the government and its agents. The lack of statements expressing the state’s obligation to provide health care for its people could very well be linked to either a continued sense of distrust in the state or to a strongly developed feeling that one must be self-sufficient and cannot rely on the government to provide anything. While this traumatic history does not preclude the development of biological citizenship, the types of neoliberal programs and policies enacted during Pinochet’s time may be playing a larger role in how people conceptualize themselves, their health, and their needs. As mentioned in Chapter 6, the social structural changes in China during the Cultural Revolution led people to feel distrustful, and neurasthenia as an illness became an acceptable expression of complaint.

The final component of the question about biological citizenship was how one’s social locations, such as class and gender, impact the experience of depression. Matching with Alejandro’s assertion about those within the in-patient facility, most of the people observed and interviewed for the project who had depression were women, and were primarily from lower socioeconomic backgrounds. From a qualitative standpoint it is not possible to generalize

beyond the data to the level of the population, but several things stand out. As elaborated in Chapter 5, many of the women observed or interviewed had experienced the loss of a loved one, and at times the loved one was a man they viewed as a source of stability or authority in their lives, such as a husband or father. For poor women, the loss of male figures in life could lead to economic insecurity, in which case women would have to develop new ways to manage life, taking on the obligations and responsibilities that male figure had previously. Some women described scenarios of being abused by their male partners; leaving those partners could have caused similar anxiety about one's economic situation. Many women explained that depression came from feeling overburdened with responsibilities, even when men were present, as explained by Estefania (Chapter 6) in her comments about gender equality. Most of these social factors that women brought up as influential in their lives and as impacting their feelings of depression were things the women felt powerless to change. By interpreting depression as an illness, and with medical services accessible and available for depression, women could be empowering themselves by taking control over something in their lives they feel they can change. Conversely, as the biopolitical orientation of society encourages individuals to self-regulate their bodies while obscuring the social context in which depression has arisen means that women's responses to life experiences and demanding social conditions are medicalized in this setting.

Biopolitics

In the context of the theoretical framework for this project, the concern becomes the extent to which depression was utilized as a case of population management through biopolitics. Biopolitics, as the formulation of social problems as related to health through biological, scientific, population-level, political, and economic mechanisms, along with the operationalization of those constructions and execution through transformative mechanisms,

represents a sophisticated, top-down, deterministic approach to considering the management of societies.

Most evident from the ethnographic component of the project are the transformative mechanisms relating to depression; that is, pharmaceutical interventions were present and heavily promoted in the management of depression as a significant health concern. All of the patients who were interviewed for the project had spent some time taking anti-depressants, some participated in psychotherapy sessions, while others were hospitalized or went through electroconvulsive therapy. Each of these intervention techniques makes use of a certain set of knowledges, construction of depression as a problem, and articulation of that knowledge.

Regarding articulations of knowledge, the reliance on experts within the health care system was the most apparent. Patients and outsiders both pointed to the necessity of going to a psychologist or psychiatrist to have assistance in navigating and overcoming depression. Part of this reliance was the idea that those with depression could not just ‘snap out of it’ or quit feeling depressed at will, and the other component of the reliance on psychologists and psychiatrists as experts was the understanding that through extensive specialized training, these people held the most reliable knowledge and knew best how to handle the disorder.

Whether the construction of knowledge is biopolitical within the ethnographic data – that is, simultaneously at a population level, scientific, biological, political, and economic – is a bit more complicated. To start, depression was conceptualized as having some biological component as for patients it meant being out of control, and for outsiders, many believed depression to be endogenous, rooted in the brain, in biochemistry, and in genetic predispositions. Psychiatrists and nurses indicated that biology was the first area they explored with patients in figuring out how to handle each unique case of depression.

Very few scientific conceptions of depression arose, with the few occasions being Daniel speaking about multicenter studies finding Santiago to have high rates of depression. In Hospital del Salvador, once a week there was a clinical lecture series that would discuss topics around mental health and psychiatry in general, often drawing from research studies that had been conducted. Patients and outsiders did not talk about depression as scientific or being based in research studies.

Participants to some extent discussed economic aspects of depression, in that providers and outsiders believed financial hardship could generate stress leading to depression. Lack of economic opportunities was also believed to contribute to depression. Vicente was most outspoken in his belief that depression was an economic problem stemming from capitalism and the push to participate in the economic system through consumption and competition with friends and neighbors.

Depression was clearly interpreted as an issue affecting the population, especially in statements about how fashionable, popular, and normalized depression was. The feeling that depression was very high among Chileans and that the prevalence of depression was increasing indicate a match between theoretical notions of a health problem at the population level, although interview patients, instead of conceptualizing depression as a health problem for the entire population, expressed that depression was a problem of stress for individuals which had become so commonplace that for the population, depression was a way of life often unrecognized as illness.

Depression as a political issue was largely unexplored by participants. In a Foucauldian sense, for depression to be political would mean that depression was understood as being used by actors as a mechanism to leverage power in managing the population. The inclusion of

depression within the national health care program was a non-issue for participants, some of whom were unaware and unconcerned that depression was included in *AUGE*. Some care providers explained the role of the dictatorship in shaping contemporary social relationships, as the cause of major change to a political system that disrupted entire ways of living. However, depression was not explained as part of the use of power to manage the population.

Through the eyes of those within the field sites, depression did not perfectly fit the mold of biopolitics. Rather than depression being constructed through the components of biopolitics, depression meant the accumulation of problems in life to the point of becoming overwhelming and causing sadness. As several care providers pointed out, depression has become a cultural catch-all signifying suffering rather than depression understood through its clinical definition.

Under biopolitics, illnesses are important in their effects on the overall population not in terms of death but how they negatively impact production and in terms of the high costs of treatment (Foucault 2003). Participants in interviews expressed that depression was an illness in terms of biology and depression's impact on involvement in daily activities, although not necessarily related to the economic impact of not working and not at all with regards to national economic impacts.

Biopolitics aside, comparing the WHO logic, motivation, and expectations for the MIND Project and its effects on the population, with the sentiments shared through interviews and observations reveal some inconsistencies. Whereas a major factor in MIND is the negative cycle between poverty and mental illness, people identified economic hardship as inspiring depression not through solely living in less than ideal conditions but because of lack of opportunity for work or to advance. When the problem is the inability to work because jobs are unavailable, intervening at the level of depression will not have the desired effect the WHO argued, of lifting

individuals, families, and entire nations out of poverty to advance economic development. Rather, treatments for depression work to mask personal frustration with a social structure unable to provide for all of its members. Medicalizing discontent in this way also removes pressure from social structural conditions by emphasizing something is wrong with the individual, similar to what many others have found (Conrad 2007; Zola 1972). This medicalizing logic could have the effect of creating false consciousness in the sense that people generally do not connect shared social conditions with their suffering. Yet, some people who participated in interviews explained aspects of society and social life that impacted depression; usually for patients this was in the context of speaking more broadly about depression, but when talking about their own specific circumstances patients attributed depression to interpersonal relationship complications, not broader social characteristics. Treating discontent with the social structure under the guise of an illness manifested by and through physical and mental characteristics works to create the notion that, as Cristobal (psychiatrist) said, “Chileans are like that,” that an entire population is ‘naturally’ prone to being depressed and further that depression would become a way of life.

As mentioned in Chapter 6, the strength of biopolitics as a theory is explaining the top-down use of power as a governance structure, for example between a state and its citizenry. Where biopolitics falls short is in providing an explanation for relationships between lay groups, as in the case of the stigma faced by those with depression from outsiders and others in society. Another difficulty with Foucault’s original theory of biopolitics is that it does not adequately account for pre-existing social obligations, roles, and expectations, such as found by gender. Biopolitics seems to both play off of and enhance existing inequalities, which in the case of women intensifies the probability of being captured by that biopolitical system through treatment for depression, mental health, and health concerns more broadly.

Biological Citizenship

Studies in biomedicalization posit that as a result of society's intensifying focus on health through technoscience, not only knowledge but identities are transformed (Clarke et al. 2003, Clarke et al. 2010). The concept of biological citizenship captures the notion that biopolitics goes beyond management of society and into a way of socializing individuals to think of themselves. One of the major research questions for this project asked about the extent to which people viewed themselves as biological citizens, which requires answers to two questions. First, how much did those diagnosed with depression see their problems as rooted in biological issues? Second, how much responsibility did those diagnosed with depression place on the government to care for their biological health problems? Few patients explained depression as a biological problem for themselves; rather, patients turned to the social world around them to explain why they felt depressed. Most patients articulated that *AUGE* was a program that provided treatment for some health conditions, but none expressed that the government should be held responsible for the care of its population. Many received free or low cost services, although they did not talk about a sense of the state having an obligation to care for them. Vicente's statement about depression being financed, rather than indicating the government's responsibility for the population's health care, signals that the government involvement is a perk of depression as an illness experience rather than an expected response to a health need.

As caveats, however, most participants in the study did interpret and understand others as interpreting depression as an illness, which implies biological dysfunction. Additionally, while patients did not explicitly say that the government should be held responsible for their medical care, making use of a government-supported health care program and plan that includes depression for a low cost does place demands upon the state to both provide access to and cover

the costs of treatment. A few patients expressed gratitude that through the vision of depression as an illness, and through developments in the health care program, treatment for depression easier to obtain and was cheaper than it had been historically.

Biological citizenship in this context has not taken shape as predicted by social theorists (Clarke et al. 2003, Clarke et al. 2010, Rose 2007, Rose & Novas 2005). Rather, the specific local sociopolitical historical context has overridden any ‘trickle down’ of knowledge or sense of who is responsible for the health and wellbeing of citizens. The history of social medicine in Chile may help to explain why biological citizenship was different in this case. Going back to Salvador Allende’s 1939 publication *The Chilean Medico-Social Reality*, health issues were examined through their connections with larger social problems such as poverty and unemployment. This perspective held popularity in the public eye until the dictatorship period, but due to the violence of the dictatorship, people may have been unwilling to make demands upon the state as this could be seen as making a potentially costly – or fatal – political statement.

The “Beyond”

Through the use of extended case method, the aim of this project is also to adjust, modify, or enhance the theoretical framework in which the research was situated (Burawoy 1991, 1998). Both theories of biopolitics and biological citizenship have already been criticized as being top-down and overly deterministic, leaving little room, if any, room for grassroots resistances to governance structures. This section explores what was found through the data collection and analysis that is left unexplained by biopolitics and biological citizenship, with a recommendation for improvement.

In Chapter 4, discourse analysis revealed that “risk” was a major theme prevalent throughout the texts that is not adequately accounted for by Foucault’s original theory.

However, the concept of risk is inherent in more contemporary theorizations of biopolitics, such as those by biomedicalization theorists (Clarke et al. 2003, Clarke et al. 2010). Within the biomedicalization literature, biopolitical constructions and articulations of knowledge as well as transformative mechanisms are assumed to undergird the major shifts in the use of science and technology as management tools in health and health care systems today. In this context, risk represents the possibility that an individual may be affected by a particular condition, disorder, or illness although that individual has not yet suffered from it; the potential for developing an illness, under a biopolitical system, requires management by the individual.

Another component of biomedicalization is a focus on optimization, that is, on enhancing populations to be “better than well.” Foucault, too, emphasized optimization as a component of biopolitics and the “making live” of populations for maximum efficiency and productivity. In Foucault’s original formulation of biopolitics, society would work to alleviate or eliminate those biological problems within society that inhibited the population’s productive capacity. The use of power through biopolitics functions explicitly to generate and reinvigorate citizens as efficient, high-capacity, productive workers, although Foucault does not spend much time exploring how capitalism as an economic system could co-produce a biopolitical governance structure³⁵. Depression is conceptualized by the WHO as a biological problem with negative effects for employers through absenteeism and presenteeism, with calculations about the amount of money lost to depression. The use of DALYs as a measure of years of productive life lost to disability, and in this case depression, is only problematic in a system that not only values but depends on economic productivity for survival. Health care systems function to return citizens to a state of well-being, thus fostering viable employees who will reach their potential within a

³⁵ Foucault does argue that capitalism utilized biopolitics to socialize bodies and create individuals as part of a labor force (Foucault 2004a).

work setting. Health care practitioners working within these settings direct patients in which interventions to use for best effects, in the shortest amount of time. As the products being worked upon through the health care system, patients from the general population represent new forms of capital, and as the biopolitical system defines the population as made up of bodies-as-biological-processes, that the population itself becomes biocapital for circulation within an economic system of work. Through the construction of mental health care as necessary and a point of intervention in economic development, healthy people are important in their capacity to engage in paid labor activities, thus being objectified and commodified as such.

Using biopolitics, power can manipulate the way individuals imagine their own problems and who they deem responsible for managing them. The emphasis on self-regulation within a biopolitical system obscures for individuals the social influences that may have impacted their health, instead turning the gaze towards the biological processes within one's own body. Inspiring people to do what's best for the good of the whole through biological interventions, eases the management of the population. Through biopolitics' inspiration of self-regulation, people should come to see themselves as working for the common good although in competition with others.

The development of programs and policies making use of neoliberalism during the Pinochet era may have more heavily shaped the participants' thoughts about depression and their own mental health experiences than the ideological leanings of more recent health interventions by the WHO. In the Chilean context, the dictatorship sparked a new variety of capitalism through economic "shock treatments" (Klein 2007). Disaster capitalism, as named by Klein, refers to the ability of Friedman's neoliberal economic policies to find success through exploitation of contexts within which crises or disasters were occurring, implying that the

creation of such crises may have been with the explicit intent of advancing such economic reforms. The joining of biological management and disaster capitalism would mean an escalation of regulating one's self to keep up with others.

The joining of neoliberal logic with biopolitical management techniques leads to an intensification of the notions of individual responsibility and self-regulation. The ways in which problems are constructed in biopolitical systems as relevant to individuals but affecting populations, of being scientific, biological, political, and economic, draw attention away from the social structure or social aspects of the issue, easing the management of the issue itself by placing responsibility for action on individuals to bring themselves in accordance with what is determined to be best for the population. Through biopolitics' inspiration of self-regulation, people should come to see themselves as working for the common good (as defined by those in power), although in competition with others. The Pinochet regime made use of neoliberal policies that would depoliticize many aspects of life, leaving society to find balance through market forces alone. The "third way" neoliberalism enacted in Chile promised economic growth accompanied by social equity (Taylor 2006), although this social equity is now questionable as Chile is a global leader of income inequality.

As for biological citizenship, a few differences must be accounted for. First, those suffering from depression did not elaborate depression as solely biological, or in specific terms relating to biological processes within the body. By not fully explaining depression in a biological way, in a context where it has been stigmatized leaves depression still in a shroud of mystery, requiring reliance on experts to aid in interpretation, management, and resolution of depression. That is, by not sharing all of the global and national psychiatric truth discourses about depression, mental health experts retain their authority and necessity in society. Second,

those suffering from depression were not actively asserting that the state should be held responsible for their health care. In Petryna's original articulation of biological citizenship (2002, 2004), victims from the Chernobyl explosion were arguing for medical coverage they believed the government should have provided, as it did not already exist. The patients within this project were recipients of a relatively recent, although pre-existing, program to help in the treatment of depression.

Pre-existing constructions of biological citizenship explain biological citizenship is an active, ongoing process created from the bottom up by individuals who are reframing their problems in terms of health and consciously petitioning the state to care for those needs. The creation of communities or social groups around health statuses as elaborated through the concept biosociality (Rabinow 1996) is similarly an active process. In the current study, individuals understood depression as an illness and utilized the national health care program to receive free services for depression; however, depression was not a galvanizing force for people in the ways that conditions such as breast cancer have been (Klawiter 2000, 2008). Those involved in this research project were not involved in activism around depression, although it had become incorporated as part of the cultural script of normal living conditions. Depression was seen as being a lifestyle or way of life. As a clinical category had become broadened and also that people saw extreme sadness, discontent, and suffering as part of the expectations of life, and having been taken for granted by some as their mode of everyday existence to the point where Chileans were understood as merely having a propensity for depression, depression had become etched into individuals' habitus (Bourdieu 1977). Accessing the health care system when life became too unbearable was an ordinary occurrence, and through use of the *AUGE* program, an unquestioned draw upon the state for the provision of care.

The notion of an active biological citizenship does not fit well with the findings of this study. Several components contribute to this, including the *AUGE* program which provided care for depression. With a health program in place to help people resolve their illnesses, disorders, and diseases, the participants in this study may have felt that the government was already fulfilling an obligation for care, and thusly did not pursue options to engage in activism against the state on this matter. However, as is well documented, more and more people have been receiving treatments for depression through the *AUGE* program, and because of the financial cost associated with paying for antidepressant pharmaceuticals and reimbursements to hospitals, this is too is a demand on the state, although it is quite different from the demands made by those affected by Chernobyl (Petryna 2002, 2004).

The findings of this study point to the need for a reconceptualization of biological citizenship. The new *gradational biological citizenship* exists as a spectrum going from active to passive and based on a number of factors, including:

- (1) The level of involvement or activism of those considered to have the health condition, disease, or disorder, in making health care an obligation of the state.
- (2) The types claims-making by those affected by a health condition, including whether claims-making is overt and explicit or an implied, assumed expectation.
- (3) The degree to which access to health care services is already granted by the state.

The above considerations allow for gradations of biological citizenship, especially in situations where knowledge transfers from the top down, of what knowledge is generated through or used by the power structure could be seen as incomplete. Gradational biological citizenship also enables the consideration of multiple levels and types of power from the bottom up, as well as the notion of power working discreetly, in line with Foucault's argument that

power is diffuse and dispersed, not held by solely one entity but used across a field of social relations by many different actors (Foucault 2004b).

Conclusion

This dissertation made use of qualitative, ethnographic data collection and analysis techniques to gauge the degree to which global psychiatric knowledge circulated and shaped individual understandings of mental illness as proposed by social theorists and global aid organizations. The case of depression in Chile, through observations of the psychiatry departments of two public hospitals and interviews with patients, providers, and outsiders, showed that the disorder was much more complex than a clinical diagnostic category indicating a neurochemical or biological problem of individual bodies. Rather, depression was interpreted through the lens of the social, where it was seen as a popular or fashionable disorder to have, to the point of seeming normal and perhaps going undetected by many who experienced it.

While biopolitics was a useful theoretical frame for considering global and national level knowledges of depression, biological citizenship to evaluate the individual perspectives on depression did not fit as well. This chapter has suggested reformulating biological citizenship along a spectrum of active to passive involvement in the consideration of both an individual's problems as biological health issues, and the people's demands upon the state for medical care. The use of gradational biological citizenship could better capture the subtleties of power and the inspiration of biopolitical thinking of individuals about their own experiences.

CHAPTER 8: CONCLUSION

This dissertation research originated with an interest in the circulation of psychiatric knowledge from global, official organizations to the level of local, individualized, and personal experiences of mental illness. Through a qualitative approach to the circulation and perceptions of psychiatric knowledge and mental illness experience, this project aimed to assess the degree to which depression was managed through biopolitical governance as well as the inscription of depression on subjectivities through the making of biological citizenship.

The global mental health movement has worked to increase access to mental health treatments in primary care and to increase legal protections for the human rights of those who experience mental illness. Mental illnesses and depression specifically are problematized as increasing public health concerns, through the calculation of Disability-Adjusted Life-Years (DALYs) showing that depression is one of the top leading contributors to DALYs globally. The World Health Organization's MIND Project is an example of a project working under this frame to resolve unmet need for psychiatric care. Working within the logic of the cycle of mental illness and poverty, the WHO expects that those in poverty are predisposed to mental illnesses whereas those who experience mental illnesses are more likely to fall into poverty because of an inability to work. By intervening at the level of mental illness, the MIND Project is also intervening on personal and national economic well-being and development. The MIND Project explicitly aims to see that interventions for mental illness, when taken on an aggregate level, will help to raise countries out of poverty. Through interventions at the level of national legislators

and health care providers, the WHO anticipates that global psychiatric knowledge will trickle down to the level of the general population.

The theoretical framework for this research comes from notions of governance through biopolitics, as the “making live and letting die” of certain people within society; biopolitics is an essential component of contemporary discussions of biomedicalization (Clarke et al. 2010). As a population-level management technique, biopolitics operates through the construction of health issues plaguing the group as simultaneously biological, political, economic, and scientific with a focus on optimizing bodies in the name of the public good. As an effect of living in a society so intensely focused on health as biological processes within the body, individuals are socialized to explicitly see themselves using the same biologically-colored languages, and actively demand from the state that their health concerns are cared for. The research questions were meant to question how biopolitical the MIND Project and national-level depression discourses were in order to assess how such discourses affected experiences with depression as well as the shape of biological citizenship within the context.

Chile has been touted as a success story within global mental health. The MIND Project operated in the country from 2003 to about 2008, with accomplishments such as the development and implementation of the Charter of Rights and Duties of Patients which was approved by the legislature in 2007, as well as lobbying legislators in the country as well as a workshop for mental health leaders in the country in May 2007. Part of the cited success of Chile is the increase in the number of people treated for depression over time, from around 29,000 in 2001 to over 275,000 in 2009 (Minoletti, Rojas, and Sepúlveda 2010). In an overlapping time period from 1992 to 2004, the use of antidepressants in the country went up over 470%. In 2002, 3% of men and 6% of women had depression, but in 2009 17.2% of Chileans had some elements of

depressive symptomology. Some studies have found up to 30% of the population to be depressed or have depressive symptoms, depending on the specific tool used to inquire about depression.

What requires pointing out with regards to this seeming explosion of depression diagnoses and prevalence in Chile are developments in health care in the country. In 2001, the national program for depression was unveiled, and in 2005 *AUGE/GES* included a pilot program for depression which was officially incorporated in 2006. It may not be that the number of people has increased so drastically, but that the provision of mental health care services for low or no cost has made treatments more accessible, especially among the poor. In the context of a population with an average expendable income of just over \$11,000 per year (OECD 2014), for poorer families the \$75 they may have to pay for hospitalization would still be quite expensive. At the time of fieldwork the *AUGE* program included coverage for the same four mental illnesses included in the MIND Project: depression, schizophrenia, alcohol and drug use.

Chile provided a unique sociohistorical context for this research for a number of reasons. Chile has a long history of involvement in global aid programs, as described in Chapter 3. Chile has been involved with the World Health Organization in various projects for decades. The Pinochet era (1973-1990) was a time of massive social and economic change for the country, due to repressive government tactics; the torture, killing, or “disappearing” of perceived political adversaries; and major economic and social restructuring and economic “shocks” during that time, meant to jumpstart a new form of neoliberal capitalism.

As a project concerned with the meanings people held around depression as an illness category and experience, qualitative methods were used to collect data. Santiago was chosen as the city in which to conduct research, because over a third of Chile’s nearly 17.5 million people

live in the capital city. The psychiatric departments of two public hospitals in Santiago served as primary sites for data collection, including in-patient and out-patient services, a day hospital, and a psychiatric emergency room. Eighty interviews were conducted in total, with patients, mental health care professionals, and a group of people who were outside of the medical realm. A discourse analysis provided the backdrop for the interviews, through an examination of the global and national texts which presumably shape psychiatric knowledge in the country.

The global and national texts had slightly different goals overall, although biopolitics was a fitting frame for analysis as many components of biopolitical governance were exemplified through the global and national mental health and depression texts. The articulations of knowledge, or the ways in which psychiatric knowledge was operationalized or rendered visible, differed between the two levels because of their varied goals. For the global level, articulations of knowledge demonstrated how the involvement of the MIND Project has helped Chile reach the WHO's legislative goals, while at the national level the Ministry of Health or other documents determined how to assess and manage an individual's mental health, whether from the perspective of the person experiencing it, their friends, their family, or care providers. The transformative mechanisms explained in the global texts were aimed at shifting state governments and mental health standards through avenues of action governments could opt into, while the national level was concerned with modifying individuals through various treatments.

Those interviewed for the project had complex and at times contradictory views about depression. Patients largely perceived problems in their lives to have precipitated their depression, although recommendations for what one with depression should do focused on seeking medical care and using pharmaceutical interventions. When patients used biologically-colored languages to talk about depression, it was through tropes of illness. As part of being an

illness, depression meant inexplicably being out of control of emotions and thoughts. Outsiders, on the other hand, expressed depression as a biological phenomenon occurring in the body, while suggesting that those with depression improve their mental health through engaging in new activities such as yoga, or going for a vacation outside of the city. Outsiders and providers were much more likely to use “atomized” language with regards to depression, i.e., discussing microscopic components of the body such as neurochemicals. Care providers often explained depression using a biopsychosocial model wherein depression was firstly coming from a biological predisposition, but was influenced by psychological development and influential life events.

Technoscientific interventions such as antidepressant drugs were quite common within both research sites. Antidepressants and electroconvulsive therapies were two treatments provided for low or no cost through the AUGE program, recommended by both the WHO and Ministry of Health discourses. While psychotherapy was also covered by the AUGE program, it was not as frequently prescribed by attending psychiatrists. The reliance primarily on intervention strategies targeted at the level of individual physical bodies and processes through the use of scientific, technological tools and the inclusion of those tools in the AUGE program demonstrate a biomedicalization of public health. Using the logic of intervening in mental health to reduce poverty through enabling productive (read: gainfully employed) citizens, particularly within a biopolitical governance structure, leads to treatment strategies oriented towards enabling individuals’ optimal performance in work related tasks. That such strategies within a biopolitical governance structure utilize pharmaceutical and technoscientific tools aimed at managing the health of physical bodies emphasizes the importance of maintaining good biology. Working on

people through biomedical treatments for mental illness to create productive workers represents a rearticulation of good biology-as-capital, or biocapital.

Chilean women experience depression much more often than Chilean men. Women who were interviewed as part of this project expressed a sense of feeling overwhelmed because of the loss of an important male figure, interpersonal conflict with male family members, and having been abused. One woman even suggested that gender equality in the workplace, while appreciated insofar as it represented an advancement in women's rights, meant that women were now saddled with additional responsibilities beyond the traditional home setting. That this feeling of being overwhelmed, overburdened, and exhausted was rearticulated through the lens of mental illness and depression worked to decontextualize women, problematizing their reactions to and dissatisfaction with complex social situations as individualized negative emotional states to be remedied through psychiatric treatment. In this way, women's experiences became medicalized.

Depression had become a popular mental illness, to the point where in everyday conversation it was referred to as simply "*depre*" (from the Spanish *depresión*). Interview participants felt depression was not only fashionable but had become normalized within everyday experience, just like hunger or thirst. Mental health professionals felt that part of the perception and actuality of increasing depression diagnoses was due to poor psychiatric training of primary care providers as well as the constraints of the AUGE system only covering a few mental illnesses. The seeming overdiagnosis of depression led to a broadening of the meaning of depression, where instead of its clinical meaning, within society depression stood as an expression of general suffering.

Some outsiders believed depression to serve as a mechanism of gaining social prestige for those who were diagnosed. Several people noted that depression had become so common and normal within everyday life that many people who had the disorder did not even realize it: depression was a way of life. The way of life described by some interview participants was a change from past times, interviewees expressed. They explained that life was more fast-paced, competitive, and individualistic, leading to feeling disconnected from others within their neighborhoods, communities, and society in general. The sense of disconnect, or anomie in Durkheimian terms, would lead individuals to feel overwhelmed and saddened. As with the narrow focus on women's reactions to circumstances in their lives, the biologization of a sense of disconnect from society indicates a medicalization of anomie. A focus on psychological reactions rather than the complexities of a changing society or women's experiences leads to resolutions of those psychological states through work on physical bodies and minds rather than the social triggers that may have brought about feelings of sadness.

The vast social and economic changes that took place in the country during the military dictatorship worked to create a strong basis in neoliberal policies and approaches to societal issues. The neoliberal expectation that individuals are responsible for themselves and choose to live as they are helps to explain some of the stigmatizing attitudes towards depression. The distrust of the government, of neighbors, and even sometimes of friends during Pinochet's time could have had the dual effect of intensifying anomic feelings and decreasing explicit demands on the state for care of its citizens.

The original theory of biological citizenship is elaborated as an active process where individuals are cognizant of their languages and demands on the state. However, in this study, most patients indirectly described depression as biological through the language of illness.

Participants implicitly made demands on the state through utilizing the public health care program providing them with free or low-cost treatments. The findings from this project suggest the need for a gradational biological citizenship, wherein the self-descriptive languages and demands on the state are implicit, covert, or passive. Where problems facing the population are constructed as collective, scientific, biological, economic, political, and solutions for such problems are widespread enough as to be seen as a non-issue, passive biological citizenship may be the sign of a truly effective biopolitical structure.

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APPENDIX A.

List of interview participants.

<i>Patients</i>							
<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Neighborhood</u>	<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Neighborhood</u>
Estefania	F	38	Pedro Aguirre Cerda	Silvia	F	41	La Cisterna
Florencia	F	52	Puente Alto	Isabel	F	38	San Ramón
María	F	46	Peñalolén	Guillermo	M	62	Pedro Aguirre Cerda
Martina	F	60	San Bernardo	Carla	F	50	La Cisterna
Claudia	F	48	San Bernardo	Clara	F	DNS	Ñuñoa
Magdalena	F	48	Lo Prado	Elena	F	DNS	Maipú
Matias	M	29	Maipú	Natalia	F	38	Peñalolén
Constanza	F	42	Peñalolén	Aida	F	45	Peñalolén
Francisca	F	51	La Reina	Erica	F	26	Peñalolén
Catalina	F	40	DNS	Alejandra	F	32	Las Condes
Marcela	F	22	Lo Espejo	Mariela	F	45	Providencia
Luis	M	37	La Granja	Barbara	F	52	Santiago Centro
Eugenia	F	61	San Joaquín	Valeska	F	30	La Florida
Angela	F	32	Pedro Aguirre Cerda	Julieta	F	37	Macul
Monica	F	47	Santiago Centro	Rosa	F	63	Peñalolén
Carlos	M	34	Lo Espejo	Antonia	F	55	Las Condes
Lidia	F	52	La Granja	Isidora	F	47	Las Condes
Gloria	F	37	Las Condes	Agustina	F	42	Providencia
Carmen	F	57	Punta Arenas *	Camila	F	50	La Reina
Manuel	M	61	El Bosque	Paloma	F	47	Providencia
Graciela	F	63	San Miguel	Sofia	F	52	Pedro Aguirre Cerda
Flor	F	29	Ñuñoa	Amanda	F	21	Peñalolén
Johana	F	26	Peñalolén				

DNS – Did not share that information.

* Punta Arenas is a city in the south of Chile.

<i>Care Providers</i>		
<u>Name</u>	<u>Sex</u>	<u>Profession</u>
Carolina	F	Psychologist
Paula	F	Psychiatric Nurse
Patricio	M	Psychiatrist
Cristobal	M	Psychiatrist
Daniel	M	Social worker
Leonardo	M	General Doctor
Vanesa	F	Psychiatrist
Felipe	M	Psychologist
Nadia	F	Occupational Therapist
Eliana	F	Psychiatrist
Ana	F	Psychologist
Victor	M	Psychologist
Tamara	F	Psychologist
Victoria	F	Psychologist

<i>Outsiders</i>			
<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Profession</u>
Vincente	M	63	Entrepreneur
Jorge	M	49	Teacher
Gabriela	F	31	Teacher
Luz	F	32	Teacher
Laura	F	24	University student
Emilia	F	22	University student
Flavia	F	30	Teacher
Camila	F	29	Teacher
Veronica	F	39	Teacher
Oscar	M	20	University student
Roberto	M	21	University student
Tomas	M	19	University student
Ricardo	M	39	Technician
Mariana	F	22	University student
Javiera	F	24	University student
Cristina	F	23	University student
Andrea	F	25	University student
Juliana	F	25	University student
Marisol	F	28	Teacher
Aurelio	M	28	Teacher
Susana	F	28	Teacher

APPENDIX B.

List of collected texts, including title, author, type of publication, global or national level, and assessed relevance to the project. Chapter 4 cites the item number as reference to the specific texts.

Item #	Title	Author	Type	Level	Relevance
1	Enfermedad Depresiva	Retamal C., Pedro	book	National	high
2	Suicidio en Chile	Duarte Quapper, Dagoberto	book	National	high-mod
3	Los atributos del psiquiatra moderno	Cruz, Carlos	book	National	mod
4	Estres: Entenderlo es Manejarlo	Cruz, Carlos	book	National	mod-low
5	La caravana de la muerte	Sánchez, Gervasio	book	National	mod
6	Principles of Preventive Psychiatry	Caplan, Gerald	book	US	mod-low
7	Vencer la depresión	de la Parra, Marco Antonio	book	National	high
8	De casa de orates a instituto psiquiátrico	Medina Cárdenas, Eduardo	book	National	mod
9	Depresión: Clínica y Terapéutica	Retamal C., Pedro	book	National	high
10	Salud mental en el gran Santiago	Servicio Nacional de la Muje	book	National	high
11	Psiquiatría y Salud Mental	Inst. Psiqu. Horwitz & SCSM	journal	National	mod-low
12	Guía Clínica para la Atención Primaria: La Depresión	MINSAL	book	National	high
13	Intervención Grupal para el Trat. De Depresión	MINSAL	book	National	high
14	Con tu Abrazo me siento seguro	Campaña por el Buen Trato	pamph	Comuna	none
15	Participant Manual: Yo pienso, siento, actúo	Martínez, Vania	book	national	low-none
16	Reflexión: Corte Suprema (red)	CINTRAS	journal	national	low-none
17	Reflexión: Futuro digno	CINTRAS	journal	national	low-none
18	Depresión: cuando nos duele el alma	Epilepsia Liga Chilena	pamph	national	high
19	Capital: SOS Salud en Crisis	Capital	mag	national	none
20	Historia de la Protección Social de la Salud en Chile	Urriola Urbina, Rafael FONAS	book	national	mod
21	Le Monde: La Salud en Chile y en el Mundo	Sepúlveda, Cecilia	newsp	national	high
22	La Segunda 12 Abril 2010	La Segunda	newsp	national	none
23	El Guardián de la Salud No. 72	La Segunda	newsp	national	mod
24	La Tercera 1 Abril 2010	La Tercera	newsp	national	low
25	El Mercurio 26 Marzo 2010	El Mercurio	newsp	national	low
26	El Mercurio 6 Enero 2010	El Mercurio	newsp	national	none
27	El Guardián de la Salud No. 71	El Guardián	newsp	national	none
28	La Segunda 16 Marzo 2010	La Segunda	newsp	national	none
29	La Segunda 4 Marzo 2010	La Segunda	newsp	national	none
30	The Clinic 4 Marzo 2010	The Clinic	newsp	national	none
31	La Segunda 13 Enero 2010	La Segunda	newsp	national	none
32	INC Todo me complica	Publimetro	NP ad	national	mod
33	La Nación Domingo	La Nación	newsp	national	mod-low
34	Chile Country Summary	WHO	Report	Global	high
35	MIND Brochure	WHO	pamph	global	high
36	Best Practices - Americas	WHO	pamph	global	high
37	Definition of Service Levels - MIND	WHO	pamph	global	high-mod
38	Essential Package - MIND	WHO	web	global	high
39	Policy, Planning, Service Dev. MIND	WHO	web	global	high
40	Intro to Country Pages - MIND	WHO	web	global	high-mod
41	Process for MH Policy - MIND	WHO	pamph	global	high
42	WHO MIND Country Summary Series	WHO	web	global	high-mod
43	MIND	WHO	web	global	high
44	Guía Clínica updated 2009	MINSAL	book	National	high
45	National Depression Program	MINSAL	web	national	high
46	ICD- 10 Manual on Depression	WHO	book	global	high
47	Breaking the Vicious Cycle (MIND Project)	WHO	report	global	high

APPENDIX C.

Translated images from Chapter 4.

Image 5. Assessing Psychosocial Risk for Suicide (12).

<u>Psychosocial Risk Factors</u>	Yes	No
Physical illness or chronic pain		
Physical or psychiatric disability, of the person or a family member		
Alcohol and/or drug abuse		
Severe family conflict (domestic violence)		
Living alone		
Recent birth or living with a child younger than 6 years		
Limited participation in and support from social network		
Loss of the mother (before 11 years old)		
Separation from partner in the past year		
Death of a family member in the last six months		
Loss of work in the last six months		
Severe work conflict (with damage to self-esteem)		
Family member who has committed suicide		
Previous depressive episode		
Other:		

Image 6. Recommended therapies to handle depression (44).

<p>Psychosocial interventions: Outpatient treatment, group psychosocial intervention, and psychoeducation are recommended for all people with depression, as much for adolescents as adults.</p> <p>Prescribing a structured plan for physical activity for people with mild or moderate depression.</p> <p>Prescribing people with depressive disorders to participation in self-help groups.</p> <p>Using cognitive behavioral therapy or interpersonal therapy in conjunction with antidepressants for severe depressive episodes.</p>	<p>A</p> <p>B</p> <p>B</p> <p>A</p>
<p>Pharmacological treatment: Utilizing as first line of treatment [medication], for moderate or severe depressive episodes, an SSRI antidepressant.</p> <p>For adolescents with moderate depression, use Fluoxetine with an initial dose of 10 mg daily, increasing gradually to a maximum of 40 mg. per day, based on response [to medication].</p> <p>Tricyclic antidepressants are used as a treatment of second or third choice in resistant depression, given the high risk of side effects and severe complications of overdose.</p> <p>In resistant depressions, one should optimize the dose or change antidepressants, and or boost with lithium, liothyronine, or a second antidepressant.</p> <p>In depressive episodes of bipolar disorder, mood stabilizers such as lithium, lamotrigine, and valproic acid are prescribed as first line [of treatment].</p> <p>The following medications are contraindicated in the first trimester of pregnancy: paroxetine, benzodiazepine, lithium, carbamazepine, and valproic acid.</p>	<p>A</p> <p>A</p> <p>A</p> <p>B</p> <p>A</p> <p>A</p>
<p>Electroconvulsive therapy: Electroconvulsive therapy (under anesthesia) is recommended for severe depression resistant to treatment in adults and adolescents.</p>	<p>A</p>

Image 7. “Flowchart for the Handling of the Person with Depression.” (44)

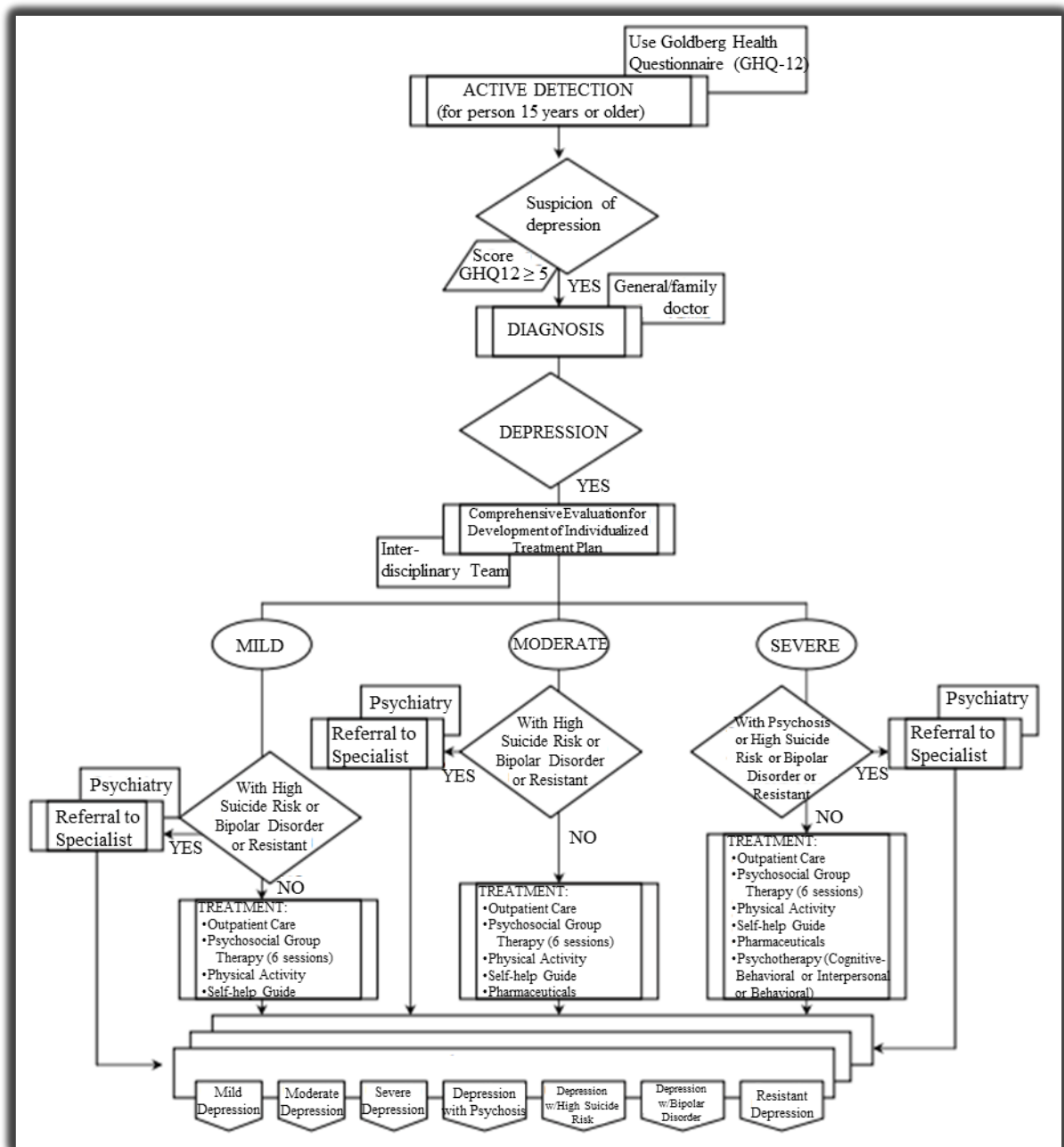


Image 8. “Evaluation of the Risk of Suicide in People with Depression: Identification, valuation, and Plan of Action.” (44)

Suicide Risk	Symptoms	Evaluation	Action
0	There is no danger.	-	-
1	Emotionally disturbed.	Investigate suicidal thoughts.	Listen with empathy.
2	Vague ideas of death.	Investigate suicidal thoughts.	Listen with empathy.
3	Vague thoughts of suicide.	Assess the intent (plan and method).	Explore the possibilities of execution of the plan. Identify and contact the person’s social support network.
4	Mild or moderate risk of suicidal ideation and mild or moderate depressive episode.	Assess the intent (plan and method).	Explore the possibilities of execution of the plan. Identify and contact the person’s social support network.
5	Moderate risk of suicidal ideation and severe depressive episode; or severe risk of suicidal ideation and mild or moderate depressive episode.	Assess the intent (plan and method).	Refer the person to a psychiatric specialist through assistant reference (direct contact with the specialty team).
6	Severe risk of suicidal ideation and severe depressive episode.	Stay with the patient (to prevent his/her access to the means).	Hospitalize the person.

(*) Adapted from the table: “Summary of Steps in Preventing Suicide,” in **Prevention of Suicide. An Instrument for General Practitioners**, WHO/MNH/MBD/00.1, Geneva, 2000.

Image 9. Goal of group therapy: from extrinsic to intrinsic motivation (13).

